

Research use and Knowledge mobilisation in third sector organisations involved
in health care provision

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Abstract

Third sector organisations (TSOs) provide health care in the UK's NHS and other health systems. One of their perceived strengths is distinctive knowledge of the communities with which they work but little is known about the knowledge TSOs possess, how it is developed and used, and how this relates to research-based knowledge. The objective of this PhD is to explore *how and why third sector organisations use research and other kinds of knowledge in their work*. Scientific Realism (Pawson, 2013) was used to develop causal mechanisms and contexts, in the form of programme theory, to explore the processes of knowledge use. A scoping review, a pilot of a survey tool, and two case studies were used to develop programme theory and to address the research questions.

I found that in the healthcare TSOs studied, knowledge encompasses tacit as well as explicit knowledge. Explicit knowledge (“know-that”) tends to be used to prove to external organisations the effectiveness of the TSO or to support organisational development; tacit knowledge (“know-how”) is used by the staff to support clients and users of services to develop knowledge of ‘what works for me’. This tacit knowledge is the distinctive knowledge that TSOs possess. It is mobilised through formal and informal relational processes. I found staff personalised knowledge to individual service-users based on individual and organisational values, implicitly integrating different kinds of knowledge in order to contribute to the benefit and flourishing of all.

These findings have implications for TSOs, service commissioners, researchers, and research funders. We need to pay attention to how values influence knowledge use and enable the distinctive knowledge of TSOs to be put into practice.

For the memory of Nigel Charles, friend, academic and pork-pie hat wearer.

1962-2018

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Contents

| | |
|---|-----|
| Abstract | 2 |
| Acknowledgements | 4 |
| Contents | 5 |
| Figures and Tables..... | 7 |
| Abbreviations..... | 8 |
| Chapter 1 Prelude | 10 |
| Chapter 2 Knowledge mobilisation and the third sector | 13 |
| 2.1 Defining the Third Sector..... | 13 |
| 2.2 Third Sector organisations and healthcare service delivery | 15 |
| 2.3 What is knowledge? | 23 |
| 2.4 Explaining knowledge mobilisation | 26 |
| 2.5 Methodological approach: scientific realism..... | 32 |
| Conclusion | 36 |
| Chapter 3 A scoping review of knowledge mobilisation in Third Sector Organisations | 38 |
| 3.1. Background | 39 |
| 3.2 Results | 44 |
| Conclusion | 63 |
| Chapter 4 Assessing research use in UK third sector healthcare organisations: using cognitive interviews to pilot the Canadian "Is Research Working for You?" self-assessment tool..... | 64 |
| 4.1 Background to the pilot survey | 65 |
| 4.2 Methods | 68 |
| 4.3 Findings..... | 70 |
| 4.4 Broader analysis of the meaning of research..... | 78 |
| 4.5 Discussion..... | 86 |
| Strengths and Limitations | 90 |
| Conclusion | 91 |
| Chapter 5 Initial explanations of how TSOs mobilise knowledge | 92 |
| 5.1 Knowledge of all kinds..... | 93 |
| 5.2 Purposes and goals..... | 96 |
| 5.3 Connections and configurations | 99 |
| 5.4 People, roles and positions | 102 |
| 5.5 Actions and resources | 104 |
| 5.6 Context..... | 107 |
| Conclusion | 111 |

| | |
|--|-----|
| Chapter 6 Methods for the case studies | 114 |
| 6.1 Case study approach and ethnographic research methods | 114 |
| 6.2 Choosing and recruiting the case study organisations. | 117 |
| 6.3 Accessing the field | 122 |
| 6.4 Ethics | 123 |
| 6.5 Data Collection | 126 |
| 6.6 Data Analysis | 129 |
| 6.7 Writing out and writing up | 132 |
| A realist approach to reflexivity..... | 135 |
| 6.8 Introducing the case studies – Chapter One Wellbeing | 139 |
| 6.9 Introducing the case studies – Carnarveon..... | 146 |
| Conclusion | 148 |
| Chapter 7 Explicit Knowledge Use by Carnarveon and Chapter One Wellbeing | 149 |
| 7.1 Internally generated explicit knowledge | 149 |
| 7.2 Externally generated knowledge..... | 175 |
| Conclusion | 180 |
| Chapter 8 Tacit Knowledge Use by Carnarveon and Chapter One Wellbeing | 184 |
| 8.1. Part One – the tacit knowledge of staff | 186 |
| 8.1.1 Knowledge of all kinds..... | 186 |
| 8.1.2 Purpose and goals of staff tacit knowledge..... | 196 |
| 8.1.3 How staff tacit knowledge is mobilised..... | 200 |
| 8.2. Part Two – The tacit knowledge of people with lived experience | 208 |
| 8.2.1 Tacit knowledge of people with lived experience | 210 |
| 8.2.2 How is lived experience tacit knowledge discovered and mobilised?..... | 212 |
| 8.2.3 The purpose and goals of lived experience tacit knowledge use | 217 |
| 8.2.4 The importance of lived experience tacit knowledge in explaining knowledge use by TSOs | 218 |
| Conclusion | 219 |
| Chapter 9 Knowledge mobilisation and the third sector: a discussion..... | 222 |
| 9.1 Knowledge of All Kinds..... | 222 |
| 9.2 Purpose and Goals..... | 234 |
| 9.3 Actions and Resources..... | 241 |
| 9.4 Using ethnography within a realist methodology..... | 244 |
| 9.5 Tacit Knowledge, the third sector and healthcare commissioning. | 249 |
| Conclusion | 251 |
| Chapter 10 Implications for TSOs, Commissioners, Researchers and Research Funders | 252 |
| 10.1 Implications for third sector organisations..... | 252 |
| 10.2 Implications for commissioners..... | 257 |

| | |
|---|-----|
| 10.3 Implications for researchers..... | 258 |
| 10.4 Implications for research funders..... | 266 |
| Conclusion..... | 268 |
| Appendices..... | 270 |
| Appendix 1 List of models included in the review by Davies et al (2015) | 270 |
| Appendix 2 Scoping Review Search Strategy..... | 272 |
| Appendix 3 Scoping Review Data Extraction Sheet..... | 276 |
| Appendix 4 Is Research Working for You? Self-Assessment Tool..... | 277 |
| Appendix 5 Participant information sheet & consent form, Pilot Survey Interview.. | 283 |
| Appendix 6 Consent form & Information sheet for Organisations participating in case study research..... | 286 |
| Appendix 7 Participant information and consent form, case study individual interviews | 289 |
| Appendix 8 Phoenix Evaluation | 292 |
| References and Bibliography | 303 |

Figures and Tables

| | |
|--|-----|
| Figure 1 Conceptual Domains of Knowledge Mobilisation | 32 |
| Figure 2 PRISMA diagram..... | 46 |
| Figure 3 Sample questions from "Is research working for you?" tool | 67 |
| Figure 4 Phoenix | 145 |
| Figure 5 Impact Report..... | 159 |
| Figure 6 Mental health and wellbeing outcomes | 161 |
| Figure 7 Purpose of evaluations and Impact Reports..... | 164 |
| Table 1 Key definitions and study eligibility criteria | 43 |
| Table 2 Characteristics of included studies | 47 |
| Table 3 Characteristics of participants | 69 |
| Table 4 Initial Programme Theories & further questions on knowledge mobilisation in TSOs | 112 |
| Table 5 Characteristics of Case Study Organisations for case selection | 121 |
| Table 6 Interview participants..... | 128 |
| Table 7 Summary of explicit knowledge mobilisation findings..... | 182 |

Abbreviations

| | |
|--------|--|
| ARBK | Academic Research-Based Knowledge |
| ASSIA | Applied Social Sciences Index and Abstracts |
| CBPR | Community Based Participatory Research |
| CCG | Clinical Commissioning Group |
| CCT | Change and Connection Trust (Case Study 1) |
| CQUIN | Commissioning for Quality and Innovation |
| DBS | Disclosure and Barring Service |
| DWP | Department for Work and Pensions |
| DH | Department of Health |
| FOI | Freedom of Information Act |
| GP | General Practitioner |
| H&SC | Health and Social Care |
| HMIC | Health Management Information Consortium |
| IRWFY | Is Research Working For You? Tool |
| KM | Knowledge Mobilisation |
| NCVO | National Council of Voluntary Organisations |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| NIHR | National Institute for Health Research |
| NVQ | National Vocational Qualification |
| ODG | Organisational Development Group |
| PRISMA | Preferred Reporting Items for Systematic Reviews & Meta-Analyses |
| SMT | Senior Management Team |
| QWP | Quality Working Party (Case Study 2) |

Chapter 1 Prelude

The idea for this research project came about following a period I spent as a Trustee with a voluntary organisation. We had a considerable amount of financial reserves in our bank account, which needed spending. So, the Board invited staff to meet with them and pitch their project ideas. Our Staff relished the opportunity to make proposals for work which they knew needed doing in their communities of interest, and the whole day was a huge success. Two projects received the funding they required, and the rest were given advice and support on how to improve their proposals for a future funding round.

Shortly after, I started my career in academia and it struck me that in making our decisions on which projects to back, the Board were not persuaded by some of the statistics and hard 'facts' which were presented: rather it was the stories which staff, and for one of the projects, a service user gave. This 'evidence' was knowledge of a different kind, and it had a profound impact on our decision making. But we did not assess whether or not the proposed ways to meet the suggested needs would 'work'; we backed projects in good faith, based on our confidence in the experience and knowledge of our staff and in the stories they told.

I reflected on the years I had spent working in the third sector and began to wonder about the relationship between voluntary and community organisations and research-based knowledge. I started to be concerned about this: as organisations in receipt of public funding via commissioning routes from local authorities, government departments and the NHS, should there not be some kind of requirement that the evidence base on which the work was founded was robust, rigorous and systematic? What was the potential for ineffectiveness or

waste, or indeed harm if what was delivered was not guided by research-based knowledge? The original project rationale was founded on this premise: that to protect recipients of third sector health care services, and to ensure that public money was being spent on doing the right (i.e. effective) things, third sector organisations need to be using research-based knowledge. But were they, and if so, then how were they doing this and why? So the focus of this research was to generate more knowledge about research use by TSOs so that they could become more effective in using research-based knowledge.

As the project progressed, this rationale soon came under scrutiny: the scoping review and pilot survey showed that lack of acknowledgement of the different kinds of knowledge that TSOs would draw upon, including the knowledge of the people who use their services, meant that a sole focus on research-based knowledge was to miss a significant part of what they were doing. Furthermore, TSOs did use research-based knowledge, but not necessarily to direct their own decision making, but to direct the decision making of others, most often commissioning and funding organisations. So the focus shifted from being a deficit-based *what the third sector is not doing, but should be*, to being asset-based *what is the third sector doing, and how does that work, for whom, in what circumstances and why?* This shift changed the balance of power within the research for me from being a researcher looking to understand what was happening so that I could offer thoughts on how it could be changed, to seeking to understand what was happening so that I could help TSOs better explain why they do what they do when it comes to research and knowledge use, and to add weight and strength to the growing need for the Third Sector to continue to be strong, independent and evidence-based.

Chapter 1 Prelude

My research used a realist approach, where theories of how and why something occurs are built and refined. Therefore, this thesis is set out to follow a format of theory building and theory refinement. The first two studies were a scoping review (Chapter 3) and a pilot study of a survey tool (Chapter 4). From these two studies, a series of rough programme theories were developed for Chapter 5 which aim to give tentative explanations as to how and why TSOs use research and other kinds of knowledge. The next chapters (6-8) cover the methodology, methods and findings from two case studies of mental health third sector organisations. Then Chapter 9 takes the findings from the two case studies and refines the programme theories from Chapter 5. Finally, in the Discussion and Implications chapter (10) the thesis concludes by discussing the overall findings in the context of evidence on knowledge mobilisation and proposing implications for third sector healthcare organisations, commissioners of such organisations, researchers and research funders.

Rebecca Hardwick

December 2018

Chapter 2 Knowledge mobilisation and the third sector

Thus, a sound conceptual understanding of the various issues at play – and their dynamic interaction with context – becomes central to the design of effective knowledge mobilisation strategies. (Davies, 2015)p.30

This chapter sets out the background that frames my work: (2.1) defining the third sector, (2.2) providing an overview of the third sector's role in healthcare delivery and their distinctive knowledge which includes a discussion of the present and historical relationship between the third sector and the state and the need for TSOs to provide and be seen to provide evidence-based services. The chapter then goes on to discuss definitions of knowledge (2.3), and processes of knowledge mobilisation (2.4) and the overarching conceptual framework used in the context of this research (2.4.1). The chapter then finishes with a series of research questions which form the basis of what follows.

2.1 Defining the Third Sector

The definition of Third Sector Organisations (TSOs) is contested and overlaps considerably with what are elsewhere called voluntary, charitable or community-based organisations (Alcock, 2010, Dickinson et al., 2012, Wilson et al., 2012). Writing in 2010, Alcock describes a strategic unity in defining the third sector, which draws together the exogenous definitions (that which the sector is not, often seen in phrases like "not-for-profit" sector, or "non-governmental" organisations), as well as endogenous approaches, which look to see what are the distinguishing, or core facets of work and activity amongst organisations of this kind. He acknowledges the difficulties within each approach, and also

highlights how over time, the role and definition of what is now called the Third Sector has changed and evolved: from "voluntary sector" in the time of the 1979 Wolfenden Report (Wolfenden Committee, 1978) to the "creation" of a third sector during the years of New Labour.

The Sector has gone through further changes in the 8 years since Alcock was writing, and now the broader terms of 'social purpose' organisations and 'civil society' organisations are also used (NCVO, 2012). However, these are overtly inclusive of a much broader set of organisations, with a much wider range of purposes so as to make thinking of them all belonging in one neatly defined 'space' in social and political life problematic.

For the purposes of my research, I conceptualised the Third Sector as comprising of organisations, taking a range of different legal forms, that all display the characteristics identified in Salaman and Anheier's work on identifying and understanding the international non-profit sector (Salaman and Anheier, 1997).

- Formally organised;
- Non-profit distributing;
- Constitutionally independent from the state;
- Self-governing;
- Benefiting from some form of voluntarism.

Alongside this, I have also paid attention to the language used by those I have met and spoken to while doing this work, and that has revealed a range of preferences and views on the different terms used: some prefer voluntary sector, others civil society, and others still social purpose organisations sector. What I learnt was that no one definition will satisfy everyone, and so I made the

judgement that I would call the organisations that this research encompasses "third sector organisations" but use that term to encompass voluntary and community organisations, and social enterprise.

2.2 Third Sector organisations and healthcare service delivery

Third sector organisations (TSOs) play an important and expanding role in health and social care provision (Dacombe and Bach, 2009, Dickinson et al., 2012, Wilson et al., 2012), with over 35,000 TSOs providing health and social care services in England (Bartlett et al., 2011). Voluntary and social enterprise providers accounted for 7% (£690m) of the 1349 contracts awarded by 182 CCGs in a 2014 British Medical Journal investigation; an increase of £350m between August 2013 and August 2014 (Iacobucci, 2014). Third sector organisations are an even more significant and expanding component of NHS-commissioned mental health care provision (Iacobucci, 2014). In 2013 mental health services accounted for about a quarter of the £542 million spent annually by the NHS on TSO-provided services (Source: DH response to FOI request, December 2013). From August 2013 to August 2014, while 45% of CCG contracts awarded were to non-NHS providers overall, 68% of mental health contracts went to non-NHS providers (Iacobucci, 2014).

The role of TSOs in healthcare delivery is founded on a long-standing relationship between the state and the sector. The Wolfenden report on the Future of Voluntary Organisations (Wolfenden Committee, 1978) highlighted the important role in social care service delivery that voluntary and community agencies were playing. At that time, voluntary organisations were more frequently grant funded through non-competitive commissioning and procurement mechanisms. The funding which they received enabled the sector

to flourish, and throughout the '80s and '90s the sector grew in terms of the size of organisations (based on turnover and staff numbers) and influence. The late 1990s saw in a new Labour Government, who sought to make the relationship between local statutory bodies, such as the NHS and Local Government and the voluntary sector more formal and so the Compact was born.

The Compact on Relations between Government and the Voluntary and Community Sector in England (Home Office, 1998) was designed as an agreement between local voluntary and community organisations, and the statutory sector on how they would work in partnership. In the opening statements, the value and contribution of the voluntary sector were set out.

The underlying philosophy of the Compact is that voluntary and community activity is fundamental to the development of a democratic, socially inclusive society. Voluntary and community groups, as independent, not-for-profit organisations, bring distinctive value to society and fulfil a role that is distinct from both the state and the market. [...]

They act as pathfinders for the involvement of users in the design and delivery of services and often act as advocates for those who otherwise have no voice. In doing so they promote both equality and diversity. They help to alleviate poverty, improve the quality of life and involve the socially excluded. The voluntary and community sector also makes an important direct economic contribution to the nation.

The consequence was there was now a much stronger requirement on public bodies to have voluntary sector representation and engagement in policy decisions. Guidance was issued on what the representation should look like: consultation on key social and welfare policies, involvement in designing services and the freedom to apply for funding to provide such services.

At the turn of the millennium, the VCS (Voluntary and Community Sector, as it was called then), was getting ever more closely engaged in influencing local health and care policy and providing services. HM Treasury carried out a Cross Cutting Review of the role of the Voluntary Sector in service delivery (HM

Treasury, 2002), and it stated that VCOs (Voluntary and Community Organisations) may be better placed to deliver services more effectively to some groups because their inherent organisational structure lent itself to the work: citing the specialist knowledge, experience and skills found in some organisations. The Review concluded by strengthening the commitment to work in partnership, to improve funding relationships and to build capacity.

In 2004, the Department of Health issued *Making Partnerships work for patients, carers and service users: A Strategic Agreement between the Department of Health, the NHS and the Voluntary Sector* (Department of Health, 2004). In this policy document, the purpose of enhancing and strengthening engagement with the Voluntary Sector was framed in the context of the need for a plurality of providers to meet the diverse needs of NHS patients and social care clients, and a need to deliver secondary care services within community-based organisations, and primary care. *Making Partnerships Work* saw the establishment of a National Strategic Partnership Forum, and the establishment of a Third Sector Commissioning Taskforce, charged with exploring and solving some of the key issues that were preventing the third sector from taking up its place in service delivery.

A few years later, and following on from *Making Partnerships Work*, the Third Sector Commissioning Taskforce, based at the Department of Health, issued a follow up consultation and discussion report *No Excuses! Embrace Partnerships Now: Step Towards Change* (Third Sector Taskforce, 2006). In this, the difficulties that third sector organisations faced in being providers were articulated, and a clear message was sent to commissioners and service providers that planning and commissioning of services did not always consider the knowledge of third sector providers about what was needed in their

community, and what kinds of services would meet those needs. Procurement and contracting placed constraints on TSOs, and the monitoring of services was onerous for small and medium sized organisations which acted as a disincentive to their participation. The direction of travel was set: the third sector would be a key partner in delivering health and care services, but to achieve this, these issues needed fixing.

2.2.1 Impact of Austerity: 2008 onwards

Since the recession in 2009, there have been further changes in the relationship between the third sector and government. A coalition government was in power from 2010, elected on a political mandate to reduce the country's economic deficit. Figures from the National Council of Voluntary Organisations (NCVO) UK Civil Society Almanac in 2013 showed a mixed picture: income for charities from investments and voluntary giving by the public fell, but trading income increased. This was partly due to increases in Government contracts (which offset the reduction in funding from Government grants). At a local level, however, for organisations delivering healthcare services on behalf of the NHS or local authority, there was less funding available. Cuts were made to contracts or were withdrawn entirely, and organisations faced annual retendering for services (a costly and time-consuming activity that diverted attention away from service delivery). Third sector organisations operating in the most deprived neighbourhoods faced what became known as a 'perfect storm' (Haddad, 2012), as rising prices, public service cuts and welfare benefit cuts increased social and welfare needs in communities whilst their funding was being reduced (Jones, 2015). Government funding to the third sector has historically been split, with most of the funding going to a small number of very large third sector organisations. These organisations are in a position to bid for

larger value contracts and to deliver at scale, whereas the smaller and medium sized organisations (which make up the majority of organisations in the sector), are not always able to bid for contracts due to changes which disadvantage smaller organisations, such as new funding mechanisms (Payment by Results) and less focus on quality (NCVO, 2017). The implication is that what funding there is then for small and medium sized organisations is harder for them to acquire, meaning that a focus on demonstrating effectiveness and impact is arguably more important.

2.2.2 Third sector knowledge.

But why was it that the state was seeking out this closer relationship, and intending for more voluntary and charitable organisations to be providing services? One answer is that the state was seeking to make sense of and benefit from the distinctive knowledge of third sector organisations (Lang and Hardwick, 2016). The UK Office of the Third Sector's 2006 Action Plan on involving the sector in public service delivery emphasised the value of the specialist knowledge of TSOs in a range of activities (Macmillan, 2010). It proposed that commissioners of public services should 'develop an understanding of the needs of users and communities by ensuring that, alongside other consultees, they engage with third sector organisations as advocates to access their specialist knowledge' (OTS, 2006 p17). This theme has recurred under subsequent governments. For example, the NHS Operating Framework for 2011/12 stated that commissioners of health services in England should consider how TSOs can 'through their expert knowledge, scope the sorts of services and outcomes that communities want and need' (Department of Health, 2010 p19)

These statements highlight how the distinctiveness of TSOs is related to their knowledge of the communities they serve and the needs of those communities. TSOs are posited as constituting an important source of local knowledge because of their 'strong links with local people at a grass roots level' (IDeA, 2009 p19). The corollary is that if this knowledge can be harnessed on behalf of public services then these services can be designed in ways that allow those needs to be met. What we have here then is an acknowledgement that there are some parts of society that only voluntary organisations can reach and that these organisations carry some kind of knowledge of communities and people which is needed although not possessed by the state.

However, it is not clear the extent to which current systems of monitoring and evaluation assess and evaluate this kind of knowledge, or indeed whether TSOs recognise that this knowledge is valuable, or how they might go about demonstrating how they use it and its impact. TSOs already give account for where funding goes in their annual reports, and if public sector funded, then through contract management and monitoring meetings.

Since 2009 all providers of NHS services – which includes TSOs – have been expected to produce an annual public report on the quality of their services (Foot, 2011) and are subject to the same scrutiny from central government and local government as other providers (Maybin, 2011). Some writers on the third sector have proposed that such pressures from the state (intended to enable governance and policing of the sector) as well as from within the sector (intended to increase TSOs' capacity to compete for contracts) push TSOs towards more corporate or standardised structures and processes and that these pressures threaten to undermine the aims and values that may have motivated a TSOs' foundation. There is evidence that TSOs are feeling these

pressures: Macmillan (Macmillan 2010) highlights the results of a 2008 survey conducted by the National Programme for Third Sector Commissioning in which more than one in three TSOs said they worried about losing their independence and more than 40% thought the delivery of public sector contracts would make it difficult for them to play an advocacy or campaigning role. Curry and colleagues (Curry, 2011 p15) observe that reporting requirements are particularly problematic for TSOs that are small or largely volunteer-run and may compromise their ability to compete in the market.

When exerted by the state such pressures may be part of attempts to control and police TSOs. Carmel and Harlock (Carmel, 2008) describe moves by the UK state to use the category of “the third sector” to represent diverse voluntary and community sector organisations. They see this as an attempt to exert governance by making TSOs generic and shifting them towards market-like modes of delivery and organisation that give the third sector the appearance of being apolitical and asocial. Harlock elsewhere (Harlock, 2015) characterises this pressure as a direct threat to the distinctive organisational characteristics of TSOs through the imposition of orthodox public-sector contracting models, models which valorise competition, cheapness, and public-sector professional standards above all else. Ilcan and Basok identify similar pressures on the Canadian voluntary sector where transformations related to federal public service outsourcing, privatisation, and contract governance schemes have turned the voluntary sector into a “community of service providers”. These changes, they suggest, have undermined the capacity of Canadian TSOs to work in the best interests of users and communities through advocacy and campaigning (Ilcan, 2004).

An important mechanism through which pressure has been applied to TSOs involves the imposition of organisational assessments of various forms, such as evaluation, target setting, audit, performance indicators, and cost-benefit analyses. Harlock (Harlock) describes the pressure felt by TSOs providing public services to produce data and evidence about the outcomes of their activities which both increases the amount of work they have to do and creates anxieties about the risks (in terms of securing future funding) of having to report negative outcomes. As one of Arvidson and Lyon's respondents reported in relation to increasing demands for evidence from TSOs, "now you need more than a picture of a smiley face." (Arvidson, 2014 p879)

In effect, these pressures on TSOs to participate in a variant of audit culture (Strathern, 2000) are centred on issues of knowledge and its use. Demands that TSOs adhere to externally imposed regimes of reporting and accounting are, in effect, attempts to use surveillance to exercise governance – or from another perspective, to discipline through the creation of knowledge about the subject (Foucault, 1991 [1977]). The risk, as Carmel and Harlock frame it, is that these audit and reporting activities present alternative logics for voluntary sector activity that replace altruism with "the imperatives of targets, efficiency and cost-effectiveness" (Carmel, 2008 p164). Subverting or avoiding such demands requires alternative ways of thinking about, using, and presenting knowledge and as Strathern (Strathern p284) observes, "what is creatively generated from 'within' can seem a kind of unwelcome complicity when it is elicited from 'without'".

Commissioners of services expect to be provided with evidence of how efforts or outcomes related to original aims and objectives, but the act of having to make connections explicit and stating them in this way alters their role in the

work (Strathern, 2000 p283). At its heart, this need for knowledge from TSOs, like all externally imposed demands for such knowledge, is a demand for linear knowledge transfer, one-way transfer of packaged information from producer to user. In doing so, Commissioners may inadvertently be missing the distinctive knowledge which they are seeking. TSOs caught up in reporting and monitoring knowledge production activity may also be unaware of what their distinctive knowledge is of their users and communities, and so are ill-prepared to use it in negotiations with funders. Similarly, the role that knowledge plays in how a TSO works, how it does its business and knows it's worth and expertise is not well understood either. Indeed, conceptualising and understanding what is meant by the 'specialist' or 'distinctive' knowledge is necessary: when a commissioner wants to buy this distinctive knowledge, do they know what they are in fact buying? Does the organisation have a sense of what it is that they "know" and are selling? The problem of what is knowledge, and in the context of this research, what is third sector knowledge needs addressing if the intention of achieving outcomes for people through third sector delivery is to be achieved.

2.3 What is knowledge?

I explored many of the different ways to conceptualise knowledge in my work, and found that the shared and common features seemed to revolve around a distinction between 'know how' and 'know that' (Orr, 2016) with know how being thought of as the craft or art of being able to do something, and know that, the declarative knowledge that a thing is as it is. In this way, scientific knowledge, that is knowledge derived from following systematic and rigorous methods aimed at producing knowledge is *know that*, whereas craft knowledge, that is knowledge derived through the process of observing others, and

practicing is to have *know how*. These knowledges are also called explicit knowledge and tacit knowledge but are not mutually exclusive; to have the skill to build an aeroplane, one must first know the facts about aerodynamics.

Polanyi (Polanyi, 1958) wrote that tacit knowledge is the knowledge needed to do something, using the example of riding a bike, but that tacit knowledge was also very difficult to communicate in a verbal or written form to others. Such knowledge which could be shared through being written down is explicit knowledge. Much of scientific research-based knowledge would fall into the explicit knowledge category, along with reports, evaluations, books and handouts: all are examples of the possibility of being able to share what is known about a thing. In contrast, tacit knowledge is much harder to share in such an explicit way: knowledge of the craft, or art of doing something, or knowing something may still be learnt, but to know how to do it, you need to do it. In this way, tacit knowledge is learnt through a process of doing and then becoming.

2.3.1 Defining Tacit and Explicit Knowledge

In my reading and thinking about conceptualising knowledge for this work, I was struck by how difficult I found it to decide what terminology to use when it came to describing and understanding tacit knowledge. Explicit knowledge seemed much more straightforward to conceptualise: it was whatever could be expressed, written down, and shared verbally, it could be research-based knowledge (of many different kinds), or it could be a handbook or a set of guidelines. The rule of thumb was that if something could be codified or expressed, through any medium, then it was explicit. In contrast, tacit knowledge was thought of as much harder to conceptualise, and it fits alongside other kinds of knowledge such as experiential knowledge and

practice based wisdom, or indeed even specific concepts of knowledges which integrate explicit and tacit knowledge, such as Mindlines (Gabbay, 2011). The literature on tacit knowledge has not succeeded in setting one clear definition for tacit knowledge (Davies, 2015), however, writing on tacit knowledge points to a shared 'family resemblance' of what it is, and how it is used and for what kinds of purposes.

However, for the purposes of my research, there were several useful conceptual footholds which I made use of:

- Tacit knowledge is a continuum, from that which it is more straightforward to describe (such as telling someone about an experience of shadowing to learn a job), to that which it is much harder to verbalise.
- Tacit knowledge can encompass experiential knowledge but is not completely summed up by experiential knowledge. Experiential knowledge lends itself towards the kind of knowledge which again can be codified in the sense of colleagues sharing the "know-how" of how to do their roles. "In my experience" is a key opener for the sharing of this kind of knowledge.
- Tacit knowledge points to the unconscious, and intangible, and in doing so opens up the endeavour of understanding knowledge mobilisation. In the context of third sector organisations, this is valuable because their organisational cultures and roles and ways of working do not primarily or always derive from book based knowledge, or the achievement of professional qualifications (although such explicit knowledge may form part of their knowledge for the job) (Dolcini et al., 2010).

However, a strict interpretation of tacit knowledge might make it impossible to research: if tacit knowledge is that which it is difficult to elicit or express, then once it is expressed, does it cease to be tacit knowledge and become explicit? Clearly, this would be an unhelpfully complex way of researching knowledge mobilisation. Nevertheless, I felt it important not to lose the intangibility of tacit knowledge in the research because as the project progressed, it became more apparent that this intangibility was of real interest and curiosity in terms of explaining the kinds of knowledge that TSOs use, as well as how it is mobilised and to what end.

Therefore, I decided that I would use Tacit Knowledge as a concept, but that it would not be a strict interpretation of Tacit Knowledge, but rather a broader term which would encompass the kind of know-how gained from practice and experience, as well as more intangible, hard to explain, "gut" knowledge. In doing this, my interpretation of Tacit Knowledge closely follows the definition used by Kothari et al in their paper on tacit knowledge of public health professionals (Kothari et al., 2012), taken from McAdam et al " [tacit knowledge is] knowledge-in-practice developed from direct experience and action; highly pragmatic and situation specific; subconsciously understood and applied; difficult to articulate; usually shared through interactive conversation and shared experience."(McAdam et al., 2007).

2.4 Explaining knowledge mobilisation

Knowledge mobilisation describes the processes through which knowledge (of many different kinds) is shared and used. The way this is understood has evolved as new knowledge and understanding of these processes has emerged. In this section, I introduce two different approaches to understanding

knowledge mobilisation processes in the healthcare context. Recent contributions to our understanding of knowledge mobilisation (KM) have focused on the messiness of the organisational situations in which people attempt to produce, communicate, and use knowledge. They draw attention to the ways in which the acceptance and use of knowledge differs according to the format and content of the knowledge concerned, to the relationships between knowledge 'providers' and 'users', and to perceived boundaries between organisations and interests. These views of knowledge and its mobilisation promote the importance of context, of relationships, and of a need for systems approaches; they contrast with views of knowledge mobilisation as relatively simple, linear, and straightforward.

In one of the clearest accounts, Best and Holmes (2010) identify conceptual approaches to knowledge mobilisation as belonging to one of three generations of models: linear, relationship, or systems. They describe linear models as those in which knowledge is seen as a product or package, in which the path from production to application moves through discrete and predictable stages, and in which communication occurs mainly in one direction, from research producer to research user. Best and Holmes' second type, relationship models, involve a development of linear models in which there is a clear commitment amongst those in the knowledge mobilisation endeavour to close collaboration in knowledge creation and use such that the core processes are linkage and exchange, collaboration, and shared learning. In such models, the focus is on sharing knowledge and on developing relationships, often in the form of networks or partnerships, between stakeholders with shared interests.

Finally, Best and Holmes describe systems models as recognising that processes of diffusion and dissemination are "shaped, embedded and

organised through structures that mediate the types of interactions that occur among multiple agents with unique worldviews, priorities, languages, means of communication and expectations” (p148). The assumptions underlying systems models are that the systems involved are dynamic and subject to constant change; that they are interdependent on other systems of greater or lesser complexity; that it is important to understand the motivation and actions of stakeholders and the ways these are informed by, and inform how, knowledge mobilisation works within a system; and that elements of systems thinking such as feedback loops and the emergence of unanticipated outcomes must be considered. Although Best and Holmes state there is no one best model for every situation they suggest systems models ensure all key factors are considered when thinking about and doing knowledge mobilisation.

Van de Ven and Johnson (Van de Ven, 2007, Van de Ven, 2006) present a similar typology and also describe three ways of framing the gap between theory and practice. First, as a knowledge transfer problem, based on a “trickle down” view of the knowledge-supply change in which academics research, produce, and test knowledge that is then taught to students, picked up and disseminated by consultants, and ultimately used by practitioners. In the second view, a distinction is made between the forms of knowledge produced by theory and by practice. This leads to exhortations that academics should “put their theories into practice [...and practitioners should] put their practices into theory” (2006 p808). Van de Ven and Johnson suggest this may be misdirected because of failures to recognise that the differences between the two groups go beyond their situation in different organisations: rather, they are *distinct epistemological communities* with internally shared knowledges that are partial and incomplete. When we recognise this, they argue, we can move beyond

simple solutions and instead work towards pluralistic approaches to knowledge coproduction among scholars and practitioners.

As a way of doing this Van de Ven and Johnson propose a third framing: “engaged scholarship”. This is based on novel ways for researchers and practitioners to work with and understand the communities in which they are located so that problems can be addressed through a broad, inclusive, and collaborative approach. For example, Van de Ven and Johnson suggest developing research projects through close discussion with the beneficiaries to ensure the research addresses real time problems or uncertainties. In this way, it motivates engagement with different knowledges and increases the likelihood that the findings of the work will be applicable to research users.

What both these models demonstrate is that the way of framing and understanding how knowledge is mobilised is in part directed by what knowledge is being mobilised, and in part by how the processes of knowledge mobilisation are understood as taking place in a complex and messy reality. Early framings of knowledge mobilisation were based on a simplistic notion that all researchers needed was to speak louder and more clearly. What more recent understandings have shown is that what counts as knowledge is important, and that who is involved, and how they share power in knowledge mobilisation is also important.

There are debates about the relative value and priority afforded to different kinds of knowledge when it comes to the practices of health care. Such debates may miss what is real and pragmatic: in making decisions on what to do, practitioners do not blindly or blithely refer to a systematic review or randomised control trial, and nor do they base their decision solely on intuition or gut feeling. Instead, there is an interplay between different kinds of

knowledges, and it is in this interplay that decisions are made (Wye et al., 2015). Potentially, a more useful debate is to consider what is it that guides such interplay? How are different kinds of knowledge learnt and valued? And how does such valuing then play out in practice?

One way of understanding this phenomenon is to see that decision-making in healthcare is a situation-specific, context-aware judgement about what to do in the here and now, with this person, or in this situation. The process of decision making does, in fact, draw upon the whole range of knowledges available to the person (experiential, personal, research based, other explicit, peer views, trends) (Gabbay, 2011).

I found Best and Holmes three generations model inspirational, as for me it pointed towards potential underlying mechanisms at work that 'caused' knowledge mobilisation (relationships and systems). Van de Ven and Johnson developed my framing further by encouraging an awareness of other mechanisms which may influence knowledge mobilisation, in particular, the idea of distinct epistemological communities. I felt this would be important for understanding the knowledge of TSOs and how it is mobilised.

In the next chapter, the findings of the scoping review into knowledge mobilisation amongst third sector organisations are given. What became apparent from doing the scoping review was that there was a range of approaches to looking at knowledge mobilisation in third sector organisations, but these were still largely based on getting the organisation to adopt an evidence-based behaviour or intervention. There was little discussion of less intentional processes of knowledge mobilisation, or indeed ones which took into account the pre-existing knowledge and autonomy of third sector organisations. The two approaches shown above are useful then in helping to understand that

the processes of knowledge use are not simple and straightforward, but in terms of being broad enough to encompass different kinds of knowledge or ways of knowing, and especially in terms of looking at knowledge mobilisation in its broadest sense (i.e. not just focusing on the uptake of research-based knowledge), I needed another approach.

I read a multi-method study (Davies, 2015) that mapped out the different approaches being used in knowledge mobilisation, with the aim of developing conceptual thinking on knowledge mobilisation and to learn from what is already known about how the "findings and insights that emerge [from research] are shared, understood and used." (p23). Huw Davies and the team at the Research Use Research Unit at St Andrew's University had been funded by the Health Service and Delivery Research fund at the UK National Institute for Health Research to attempt to bring a degree of coherence to the burgeoning knowledge on knowledge mobilisation.

One aspect of the project was a review of reviews of knowledge mobilisation, designed to answer the question, "What models, theories or frameworks have been used explicitly – or can be discerned as implicit underpinning logics – in the development of the knowledge mobilisation strategies reviewed?" (p17)

They identified 71 reviews relating to knowledge mobilisation, and from these 71 articles, they identified the main models, theories and frameworks used in knowledge mobilisation work. These are shown in Appendix 1. They developed the domains of the conceptual map inductively through reading these reviews and wider literature, and within each domain, an account was given of the relevant issues, topics and concerns. The conceptual map of the domains is shown below in Fig 1.

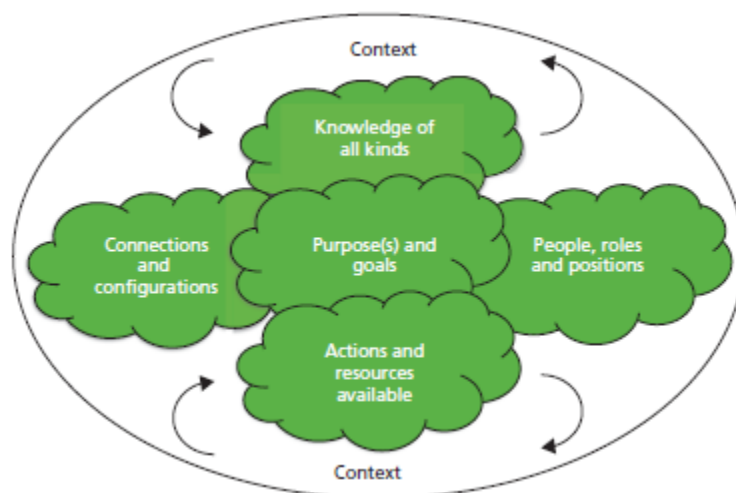


Figure 1 Conceptual Domains of Knowledge Mobilisation

The value of using this map is that it is not too specific: it allows for there to be a range of ways to understand knowledge, its purpose and goals, who is involved, and what they do. In Chapter 5 I use this conceptual map to help me build programme theory, and in that Chapter, I give a summary of each of the domains and how it was interpreted in the context of my work.

[2.5 Methodological approach: scientific realism](#)

The overall design of the PhD is based on an understanding that research and knowledge use is an inherently social process (Nutley et al., 2007, Phipps et al., 2012). It involves interaction and choices between people and is dependent on the context of both the individuals involved in the knowledge mobilisation, as well as the contexts of their interpersonal relationships, organisations and the wider social world. Organisational context (culture, norms and values) is crucially important in explaining not only how knowledge gets used in practice, but also what is seen to count as credible knowledge. As realist approaches focus on explaining how contexts hamper or foster the operation of mechanisms action (in this instance, mechanisms of knowledge mobilisation) to achieve outcomes, it provides a suitable overarching methodology for the research.

Realist methods have shown value in explaining complex interventions in health services research, as well as criminal justice, public health and education (Floyd et al., 2004, Jagosh, 2012, Anderson and Hardwick, 2016, Greenhalgh, 2008, Greenhalgh et al., 2009, Greenhalgh et al., 2007, Greenhalgh et al., 2018, Hardwick, 2013, Wong et al., 2010, O'Campo et al., 2011) Realist approaches answer the sort of questions that are relevant to decision makers, such as why did a policy, programme or intervention work in a particular setting, who did it work for, have we got the right set up here for it to work here and so on (Berwick, 2008, Pawson, 2013, Pawson, 2002, Pawson, 2006, Pawson et al., 2014, Pawson et al., 2005a, Pawson et al., 2005b, Pawson et al., 2010, Pawson and Tilley, 1997).

As a result, realist methodology is increasingly used for evaluating knowledge mobilisation strategies such as a review of 14 studies, (Salter and Kothari, 2014). In addition, recent NIHR-funded research projects have employed realist methods to explore implementation and knowledge mobilisation (Pearson et al., 2015, Rycroft-Malone et al., 2012). More generally, theory-driven reviews have made major contributions to our understanding of how and why health care innovations get spread or adopted (Greenhalgh et al., 2004).

Realist methodology centres on developing and refining theory on the effectiveness or otherwise of particular policies, programmes or interventions. They are catholic in their approach to data, seeing many different sources of knowledge as suitable for the overall effort of understanding the circumstances within which effects occur. Realist approaches are based on a realist philosophy of science, which holds that there is a mind independent reality, that is knowable, but that the knowledge of it is impartial and always open to further development. Realist approaches to research reject successionist models of

causation (the constant conjunction of events, where an event occurring is caused by another event which preceded it), and instead use a generative model of causation (Bhaskar, 1975), which is concerned with understanding how generative mechanisms, which exist regardless of whether they are active or latent, cause change, in different circumstances, and why this change occurs. The basic realist research question then is explanatory in focus; what works, for whom in what circumstances and why?

The study of reality, and what is real, and therefore what can be known about what is real is known as ontology. In realist terms, we say that we have a depth ontology: that is, there is a domain of the real, which encompasses the real liabilities and tendencies, powers or generative mechanisms inherent in the world, which are independent of our knowledge of them and independent of us. Not only this, but these generative mechanisms cause events to occur, known as the domain of the actual, and finally, that there is the domain of the empirical, where such events caused by generative mechanisms are observed (Bhaskar, 1975).

What this means for the research is that if understanding is to be developed on how and why third sector organisations use research and other kinds of knowledge in their work, then the focus needs to be on discovering the generative mechanisms operating at the level of the 'real' that cause knowledge mobilisation. Mechanisms have been variously conceptualised by Bhaskar, but in this work, the definition of mechanisms follows Pawson (Pawson, 2006, Pawson, 2013) and Dalkin (Dalkin et al., 2015), in that mechanisms are the interplay of *resources* (understood as that which is provided by a policy, programme or intervention, in this instance “knowledge”) and the *responses* of individuals or systems to those resources. As mechanisms are the product of

the interplay between reasoning and resources, it is helpful to think of their operation as being on a continuum, rather than as a switch: the idea being to understand how can we “turn up” the mechanism to achieve the required result, rather than how can we switch the mechanism “on”(Dalkin et al., 2015). So put more simply, the question is, when faced with the *resource* of knowledge, how do those that work in TSOs *respond*? Scientific realism (Pawson, 2013) uses programme theory building and refining as a way of capturing this: programme theories are explanations as to why a particular policy, programme or intervention works, for whom it works, in what circumstances and why. The mechanisms of knowledge mobilisation, operating in what circumstances cause which outcomes.

Scientific realism provided a broad framework for this PhD research. The research was not concerned with explaining the effectiveness of a specific research knowledge mobilisation policy, programme or intervention. Instead, this research was exploratory *and* explanatory, seeking to build up knowledge about what kinds of knowledge TSOs use in decision making, how that knowledge is used and to what ends. Scientific realism was used to inform the research design because the research is interested with developing an understanding of the mechanisms which cause research and other kinds of knowledge to be used and the circumstances which influence this outcome, as well as those that hamper it.

Implications for design

The design of the research, therefore, included theory building, where initial ideas about how research and knowledge are used by TSOs were developed, and theory refining, where such ideas were subjected to further analysis. To do this, I conducted a scoping review (Chapter 3) and piloted a survey (Chapter 4)

to elicit initial programme theories about how third sector organisations use knowledge, in what circumstances and why (Chapter 5), and then I explored those programme theories further in two consecutive case studies with TSOs, using ethnographic methods (Chapters 6-9). I did not use an overt realist approach in the design, conduct and analysis of the scoping review and pilot survey individually, but in Chapter 5, I used a realist approach to synthesise the findings together into programme theories.

In Chapter 6, I discuss in more depth the relationship between ethnography and realism, and how Hammersley's subtle realism (Hammersley, 2007) informed the work. Essentially though, I used the programme theories from Chapter 5 as the starting point of selecting the cases for the ethnographic fieldwork, and during the fieldwork, I used the programme theories as guides to ensure that I was collecting data which would enable me to refine them. In Chapter 9 the programme theories are refined with the findings of the ethnographic fieldwork. Then in Chapter 10 I give some implications of my research for TSOs, Commissioners of TSOs, Researchers and Funders.

Conclusion

In this Chapter, I have shown how TSOs are important healthcare system stakeholders, with a long and enduring relationship with the State. This relationship has been conceptualised in policy as attempting to harness the distinctive knowledge of TSOs with the intention of using that knowledge to improve health and care outcomes for communities. Mobilising the knowledge of TSOs in this way has received relatively little attention, which is important if Van der Ven and Johnson's claims about different epistemological communities is accurate: it indicates that TSOs may form their own epistemological

communities, and in doing so, developing their own cultures of evidence and knowledge and ways of knowing.

The implication is two-fold: the need to understand the particular features of the epistemological communities of the Third Sector, i.e. to understand from the TSO perspective what is knowledge, how it is valued and learnt and what guides its mobilisation, and secondly to understand the role and place of research-based explicit knowledge in the everyday practice of TSOs. Doing this will provide a knowledge on how to increase the use of research-based knowledge by third sector organisations, as well as provide other healthcare system stakeholders with a greater understanding of the knowledge from TSOs that they are harnessing.

Scientific Realism (Pawson, 2013) was used as the overarching methodology so that causal mechanisms and contexts could be developed, in the form of programme theory to further explanation of these processes, and the conceptual map developed by Davies et al (2015) provided the framework for theory building and refining. The objective of this PhD study then, is to explore: *How and why do third sector organisations use research and other kinds of knowledge in their work*

Chapter 3 A scoping review of knowledge mobilisation in Third Sector Organisations

In the previous chapter, the rationale and background for the PhD research were set out: Third Sector Organisations (TSOs) are increasingly providing health and care services on behalf of the NHS, they are sought out as providers of healthcare services partly because it is thought they have distinctive knowledge of their communities and clients. Accessing this knowledge through commissioning them to provide services should realise benefits for local populations, however, little is known about this knowledge, or about other kinds of knowledge that TSOs may use, such as research-based knowledge. To remedy this situation, I started my research with a scoping review of the literature to create a broad map of the evidence available on research and knowledge use by TSOs. This approach was also congruent with a realist approach to theory building, where the initial stages are to map, or scope, what might be known in a particular domain, so as to enable focus and direction for further research (Pawson, 2006).

The chapter begins in 3.1 with the methods of the scoping review and the review questions. In 3.2 the findings from the scoping review are given: 3.2.1 discusses the different kinds of knowledge health care third sector organisations (TSOs) use; 3.2.2 reports on barriers to research use; 3.2.3 reports on facilitators and 3.2.4 the strengths of TSOs in knowledge mobilisation. 3.2.5 reports on motivations for knowledge mobilisation and use and in 3.2.6 the processes of knowledge mobilisation and use identified from the literature are given.

In 3.3 the chapter is rounded off with a discussion on the implications of the review findings. What emerges is a sense that TSOs operate in complex environments, made up of multiple, interacting concerns and stakeholders which influence how and why knowledge of all kinds is used. Some issues require further exploration: understanding

what is meant by the 'context' of TSOs and how this relates to knowledge mobilisation and why within the diversity of knowledge that TSOs use, is internally generated knowledge more influential.

3.1. Background

Scoping reviews have been defined as “a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting and synthesizing existing knowledge” (Colquhoun et al., 2014).

Scoping reviews are not concerned with questions of effectiveness, like a systematic review, and nor are they about exploring causation, as a realist review would. Scoping reviews are most useful when trying to understand what is already known, what has been looked at, and where the gaps are in knowledge, particularly when the topic is emerging. I had been exploring knowledge mobilisation and research use by TSOs for several months before I started my PhD, as preparation for a doctoral fellowship application, working with a colleague that was interested in similar issues. In our discussions and searching, it soon became clear that in our field of health services research, little was published about the use of research by TSOs, and so there would be little point in attempting a conventional systematic or realist review at that point. However, there was plenty of justification for using a systematic approach to review and synthesise what research there was, and a scoping review offered the right methodology to do this. The questions which the scoping review explored were:

- What research evidence is currently available about how TSOs that provide health and social care services use research and other forms of knowledge in decision making?
- What are the implications of this research for the research community, as well as TSOs themselves?

Methods

Whilst there has been some debate in the literature on the definition and proper methods of scoping reviews (Colquhoun et al., 2014, Levac et al., 2010), the current practice still favours the approach set out by Arksey and O'Malley in their 2005 paper. They describe the following steps: 1) identifying the research question; 2) identifying relevant studies; 3) study selection; 4) charting the data (data extraction); 5) collating, summarising and reporting the results and finally 6) consultation on findings with stakeholders. In this scoping review, steps 1–5 were carried out but step 6 was omitted due to the confines of time and resources. Assessing the quality of included studies is not typically carried out in a scoping review (Colquhoun et al., 2014, Arksey and O'Malley, 2005), and so no formal quality assessment was undertaken.

Searches

The literature searching for this review occurred in two phases: (1) an exploratory search, including bibliographic database browsing, web-searching, contacting authors and experts and hand-searching of relevant journals, the results of which informed (2) a formal systematic search of a wider range of bibliographic databases and other e-resources.

The exploratory search combined third sector organisational terms (e.g. charity, voluntary, community-based) and terms related to knowledge mobilisation (e.g. knowledge transfer, knowledge exchange, research utilisation) within the PubMed database. Further searching was undertaken of websites of knowledge mobilisation organisations in the UK and Canada (e.g. Institute for Knowledge Mobilization, <http://www.knowledgemobilization.net>; UK Knowledge Mobilisation Forum <http://knowledgemobilisation.net/about>), contacting authors and hand-searching of relevant journals (e.g. Voluntary Sector Review,

Implementation Science) and revealed a small body of emerging research and published commentary on how TSOs use and generate research (11 potentially includable studies) (Kothari and Armstrong, 2011, Jack et al., 2011, Ramanadhan et al., 2012, Bailey and Warwick, 2012, Hardwick and Coffey, 2011, Hardwick et al., 2015, Lightowler, 2012, MacGregor et al., 2013, Wathen et al., 2011, Wilson et al., 2011a, Wilson et al., 2010, Wilson et al., 2011b).

The second bibliographic search was developed with an information specialist and employed a wider range of search terms to identify literature about TSOs and their knowledge mobilisation or research use. The search strategy was run in the following bibliographic databases of published and grey literature, from database inception to date of search: HMIC via OVID, Social Policy and Practice via OVID, CommunityWise via Oxmill, ASSIA via ProQuest, British Library Social Welfare Portal. A copy of the search strategy is in Appendix 2.

Study inclusion and exclusion criteria

Articles were eligible for inclusion if they were in English language and were research studies of knowledge mobilisation or research use conducted in third sector organisations which are involved in providing or commissioning health or social care services. (See Table 1 p 42 for the definitions used, and detailed inclusion and exclusion criteria).

In deciding whether a research study was about knowledge mobilisation or not, some studies presented a dilemma. Firstly, there were a number of studies about community-based participatory research (CBPR) in which, as the abstract of one of these studies stated, CBPR was used mainly as “a strategy to develop trust and build on the strengths of partners from various settings to address significant health issues” (p133) and where the partners commonly included both academic research teams and community organisations (Shoultz et al., 2006). Such participatory or collaborative research usually involves

developing relationships between one or more research institutions and one or more community-based organisations (Washington, 2004) and could, therefore, be seen as direct examples of knowledge exchange through relationship building between researchers and potential research users. Similarly, collaborative community-based “action research” can be seen as a knowledge mobilisation process that brings together services providers and service users and the public—albeit one where the processes of knowledge generation (co-production) and implementation are indistinguishable. However, as these studies focused on whole communities, where the TSOs were just one of a range of actors involved, they were not included.

Secondly, some studies examined the variation in the uptake of “evidence-based practices”, and so did not fit with the objective of understanding the *processes* of knowledge mobilisation, and research use. Even if a study explicitly labelled particular practices as evidence-based, then a study which only investigated attitudes towards those treatments (Krull, 2011) or variations in uptake was not strictly knowledge mobilisation research. Making these decisions was a deliberative process between myself and one of my PhD supervisors, and in the end we agreed that it would only be knowledge mobilisation research, if there was some investigation into the *processes* of uptake of the practice or if there was an explicit initiative to promote the implementation of the evidence-based practice (e.g. Shera and Dill’s evaluation of the impact of a knowledge mobilisation strategy on engagement with evidence-informed practice (Shera and Dill, 2012)).

Study selection

All articles were title and abstract screened by me and one of my PhD supervisors, and those eligible for inclusion were read by both of us. Further exclusions were made at this point and any disagreements on inclusion were resolved through discussion.

Table 1 Key definitions and study eligibility criteria

| Definitions | |
|---|---|
| Knowledge mobilisation and research use | <p>Intentional strategies for increasing or improving:</p> <ul style="list-style-type: none"> • research or knowledge use or • the uptake of explicitly evidence-based practices, <p>or studies of what influences decision making or practice changes (including the use of knowledge within routine organisational processes)</p> |
| Third sector organisations | <p>All organisations operating outside the formal state or public sphere that are not trading commercially for profit in the market¹.</p> <p>Third sector organisations carry out a range of functions, including providing services to the public directly (either funded by public sector organisations, or through charitable giving/grant funding), lobbying and campaigning on behalf of particular interest groups, supporting and networking other third sector organisations and building capacity (such as Local Infrastructure Organisations).</p> |
| Include | Exclude |
| English Language | |
| Research into knowledge mobilisation or research use in third sector organisations providing health and social care services, related to physical and/or mental health support and related functional wellbeing needs e.g. community children's services, community services for older people and the frail elderly | Probation, criminal justice services, welfare payments and other needs-based financial support |
| Primary or secondary research (including systematic reviews), published in peer reviewed journals or grey literature | |

¹ Source: Third Sector Research Centre website 'What is the third sector?' <http://www.birmingham.ac.uk/generic/tsrc/about/index.aspx> [accessed 22nd May 2014]

Data extraction

Data were extracted from the final set of included studies into a data extraction table (Appendix 3) to capture the following information: year of publication; author; title; country where study conducted; study aim; methods; type of third sector organisation; type of services provided; whether a specific knowledge mobilisation strategy was studied, and if so what; types of knowledge/evidence/decisions studied; identified barriers to knowledge mobilisation; identified facilitators of knowledge mobilisation; study strengths and limitations and author-identified areas for further research.

Data analysis

I undertook a thematic analysis which mapped the range of issues the included studies raised, and to identify areas for future research.

3.2 Results

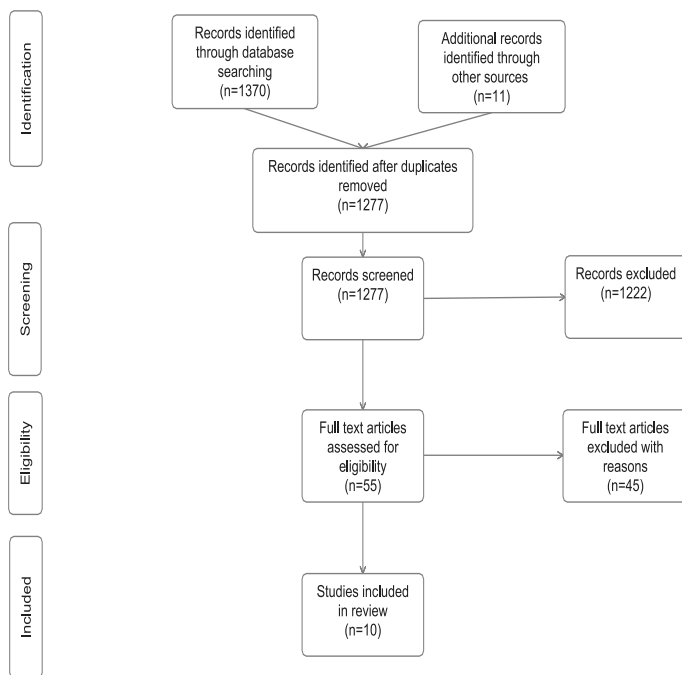
Review statistics

The eleven records from the first search were combined with the 1370 records identified through database searching in the second search. After removing duplicates, 1277 were title and abstract screened, and 1222 were excluded as not meeting the inclusion criteria. The remaining 55 articles were retrieved as full text and read for inclusion. Of these, a further 45 were excluded as not meeting the inclusion criteria. The review, therefore, included ten studies (see Figure 2 p45 for the study screening and selection process (PRISMA) diagram). Six studies were from Canada, two from the USA and two from the UK. The services provided by the TSOs included in the studies concerned HIV/AIDS care (Dolcini et al., 2010, Lavis and Wilson, 2011, Owczarzak, 2012, Wilson et al., 2011a,

Wilson et al., 2011b), child welfare services (Shera and Dill, 2012), diabetes care (Lavis and Wilson, 2011), addictions care (Jack et al., 2011), adult mental health services (Wilson et al., 2011b), child mental health services (Kimber et al., 2012) and social welfare and health care services (McLaughlin et al., 2010), or was mixed across domains of health and social care.

Four studies looked at the processes of implementation of evidence-based interventions or programmes by TSOs (Ramanadhan et al., 2012, Dolcini et al., 2010, Owczarzak, 2012, Kimber et al., 2012). Four studies looked at how TSOs use research knowledge in their work and decision making (Beddoes et al., 2012, Lavis and Wilson, 2011, Wilson et al., 2011b, Shera and Dill, 2012). Only two of these studies focused on specific strategies for mobilising research knowledge. These were Shera and Dill (2012), who looked at the use of the “Practice and Research Together (PART)” programme to “push” research into practice by TSOs via a range of mechanisms (webinars, conferences etc.); and Beddoes et al. (2012), who explored the benefits of Open Access publication to facilitating knowledge use by TSOs. Finally, two studies explored how TSOs use research alongside other forms of knowledge (tacit or experiential) in their work (McLaughlin et al., 2010, Jack et al., 2011). See Table 2 for a summary of study aims, methods and the types of organisation in which the research was conducted.

Figure 2 PRISMA diagram



do-view.com model

Table 2 Characteristics of included studies

| Author (Date) Paper title Country | Aim of research | Methods | Number/Type of organisation(s) and type of care service/client group |
|--|--|---|---|
| Beddoes et al., (2012) <i>Benefits of open access to scholarly research for voluntary and charitable sector organisations</i> England and Wales | To investigate the benefits of Open Access scholarly research outputs to TSOs | Mixed methods: (Rapid evidence review, scoping interviews (n=9), online survey (n=101), case studies (n=10)) | TSOs, many providing health and social care services. |
| Dolcini et al., (2010) <i>Translating HIV interventions into practice: community-based organizations' experiences with the diffusion of effective behavioral interventions (DEBIs)</i> USA | To investigate how agencies are translating evidence- based interventions into practice | Qualitative: In-depth structured interviews with executive directors, programme managers and programme implementers (n=15). | 6 agencies that were implementing one of these Evidence-Based Interventions: Healthy Relationships (people living with HIV/AIDS); Safety Counts (for injecting drug users); Many Men, Many Voices (for gay men of colour) |

| Author (Date) Paper title Country | Aim of research | Methods | Number/Type of organisation(s) and type of care service/client group |
|--|--|---|--|
| <p>Jack, <i>et al.</i>, (2011)</p> <p><i>Evidence-informed decision-making by professionals working in addiction agencies serving women: a descriptive qualitative study</i></p> <p>Canada</p> | <p>To explore:</p> <p>1) the types and sources of evidence used to inform practice-related decisions within Canadian addiction agencies serving women;</p> <p>2) how decision makers at different levels report using research evidence;</p> <p>3) factors that influence evidence-informed decision making.</p> | <p>Qualitative:</p> <p>In-depth telephone interviews with decision-makers (n=26)</p> | <p>24 agencies across Canada providing addiction services to women</p> |
| <p>Kimber, <i>et al.</i>, (2012).</p> <p><i>Becoming an Evidence-Based Service Provider: Staff Perceptions and Experiences of Organizational Change</i></p> <p>Canada</p> | <p>To explore the process of implementation of evidence-based practice in community-based organisations.</p> | <p>Mixed methods:</p> <p>Case study, comprising of an annual questionnaire (n=238 to 342 per year over four years); semi-structured interviews with staff across the organisation (n=13) and observation of group meetings (not reported)</p> | <p>A large community-based provider of child and adolescent mental health services</p> |

| Author (Date) Paper title Country | Aim of research | Methods | Number/Type of organisation(s) and type of care service/client group |
|---|--|--|--|
| Lavis, J. Wilson, M. (2011) <i>Community-based organisations and how to support their use of systematic reviews: a qualitative study</i> Canada | To better understand community-based organisations, and their views of and experiences with research evidence. | Qualitative: Focus group (n=31) and interviews (n=16) with same sample of executive directors and programme managers | A representative sample of community-based organisations in Canada providing care for those with (i) HIV/AIDS, (ii) Mental health/addiction problems, and (iii) Diabetes. |
| McLaughlin, <i>et al.</i> , (2010) <i>Decision-making and evidence in direct practice</i> Canada | To explore how decisions are made in TSOs, and how evidence informs those decisions. | Qualitative: Semi-structured interviews (n=15) | 9 non-profit care organisations providing a wide range of social, welfare and health services |
| Owczarzak, J. (2012) <i>Evidence-based HIV prevention in community settings: provider perspectives on evidence and effectiveness</i> USA | To explore what factors affect how HIV prevention service providers view and implement evidence-based practice | Qualitative: Semi-structured interviews with staff members (n=22) | 8 TSOs involved in care or preventions services related to HIV/AIDs |

| Author (Date) | Aim of research | Methods | Number/Type of organisation(s) and type of care service/client group |
|--|--|---|--|
| Paper title Country | | | |
| <p>Ramanadhan <i>et al.</i>, (2012)</p> <p><i>Perceptions of evidence-based programs among community-based organizations tackling health disparities: a qualitative study</i></p> <p>USA</p> | <p>To investigate how community-based organisations understand evidence-based programmes and what the barriers and facilitators are which influence their usage</p> | <p>Qualitative:</p> <p>Interviews with staff members (n=6) and four focus groups (n=31 participants)</p> | <p>A number (unstated) of CBOs working with ‘underserved’ populations in Boston, Lawrence and Worcester (Massachusetts)</p> |
| <p>Shera, W. Dill, K. (2012)</p> <p><i>Promoting evidence-informed practice in child welfare in Ontario: progress, challenges and future directions</i></p> <p>Canada</p> | <p>To measure the progress and impact of PARTs activities on child welfare practice in Ontario, including a focus on TSOs engagement with evidence informed practice</p> | <p>Mixed methods:</p> <p>Online survey, focus groups, systematic collection and analysis of feedback from learning events</p> | <p>37 child welfare organisations in Ontario involved in the PART (Practice And Research Together) programme</p> |
| <p>Wilson, <i>et al.</i>, (2011)</p> <p><i>Community capacity to acquire, assess, adapt, and apply research evidence: a survey of Ontario's HIV/AIDS sector</i></p> <p>Canada</p> | <p>To assess the capacity of CBOs in the HIV/AIDS sector to acquire, assess, adapt and apply research evidence in their work.</p> | <p>Quantitative & qualitative:</p> <p>Self-assessment survey (n=51)</p> | <p>25 community-based organisations (with ~290 full-time equivalent employees in total) providing HIV/AIDS care services</p> |

3.2.1 The diversity of knowledge that TSOs use to inform their work

Five studies reported that TSOs use a range of information in decision making and service delivery (Beddoes et al., 2012, Dolcini et al., 2010, Owczarzak, 2012, McLaughlin et al., 2010, Jack et al., 2011). Sources of knowledge included staff professional experience and clients views and wishes (Dolcini et al., 2010, Owczarzak, 2012, McLaughlin et al., 2010, Jack et al., 2011); and in some of these studies (Dolcini et al., 2010, McLaughlin et al., 2010), staff and client knowledge was preferred over other sources of knowledge. For example, Dolcini's study (Dolcini et al., 2010), identified organisational culture as a barrier to the implementation of evidence-based HIV practice, insofar as it was not seen as part of the culture in community based organisations (CBOs) to rely solely on evidence-based practice; instead, there was a preference for using their own knowledge of what works or borrowing programmes and ideas from organisations that run similar services. Similarly, McLaughlin's study (McLaughlin et al., 2010) in 9 non-profit care organisations in Canada reported that colleagues were felt to be the most important source of information for making decisions about client care. Interviewees described working issues out collaboratively as a team, feeling that drawing on their shared values and experiences was an efficient way to access information. Another source of information was the professional and personal, or experiential knowledge of the practitioner themselves. Such knowledge was made up of a range of reflections, previous experiences, and in some instances 'gut feelings'.

Clients were also sources of information; not only what they said, but what was *unsaid*; so lack of attendance at services was seen as subtle client feedback that the service was not meeting their needs appropriately (McLaughlin et al., 2010). The client's own experience was understandably important in tailoring

any interventions, with the need to remain open to client needs and to adapt interventions to suit them. Internally generated knowledge (from advisory committees, service user surveys and focus groups) was important in their work and was felt to be more influential than externally produced, 'academic' knowledge. A further source of information was professional values, (e.g. their Professional Code of Ethics), and the philosophy of their organisation.

In Owczarzak's study into evidence-based practice for HIV prevention services (Owczarzak, 2012), interviewees differentiated between 'book' and experiential knowledge, where book knowledge was used to support intervention implementation, and experiential to challenge it. The 'borrowing' of ideas from others was a source of knowledge in Jack et al's study (Jack et al., 2011).

They found that multiple types of evidence were used, without a clear preference for any particular sort of evidence, apart from relying more on locally collected information. Research evidence was used, along with best practice guidelines, and local programme evaluations and information from programmes underway in other areas which were seen as being 'best practice'. Client needs assessments, expert opinion, and personal experience (of addiction and recovery), as well as individual professional experience, were also used to support decision making.

3.2.2 Barriers to research use and knowledge mobilisation

All but two of the studies (Beddoes et al., 2012, Dolcini et al., 2010, Jack et al., 2011, Kimber et al., 2012, Lavis and Wilson, 2011, McLaughlin et al., 2010, Ramanadhan et al., 2012, Wilson et al., 2011b) described barriers within organisations that prevented them from fully making use of research and other knowledge. These barriers included resource constraints (lack of time, people,

cost, and competing priorities), organisational culture, the need but difficulties in adapting evidence-based programmes to their organisational context and problems in applying the findings of scholarly research to practice. One study described the difficulties of having staff with the time and skill to access scholarly research, assess its quality and reliability and then develop user-friendly summaries (Wilson et al., 2011b).

Other barriers were external to the organisation, in particular, the lack of scholarly research which was seen as relevant to the organisational or community contexts of community based, or third sector organisations (Beddoes et al., 2012, Lavis and Wilson, 2011, McLaughlin et al., 2010, Owczarzak, 2012, Ramanadhan et al., 2012). In Beddoes' study of Open Access Publication (Beddoes et al., 2012), they found uncertainty amongst TSOs of the value of scholarly research to their organisational contexts and that the multi-disciplinary nature of how third sector organisations work (across communities, sectors and settings) did not lend itself to the way that research is organised into specific disciplines and journals, each requiring a separate subscription by the TSO. McLaughlin's study (McLaughlin et al., 2010) again found that academic research was seen as irrelevant to TSOs local contexts, and it appears from Ramanadhan's study that even when a TSO wants to adapt an evidence-based programme to make it contextually relevant, funders would often not permit these (necessary) changes (Ramanadhan et al., 2012).

Lavis and Wilson explored the utility of systematic reviews for community based organisations, and some participants reflected that there may be limitations to the knowledge from systematic reviews and problems in applying the findings to their organisational context (Lavis and Wilson, 2011). In particular, systematic reviews which lacked a detailed description of the programme or intervention

were unhelpful, as was lack of detail on how and why particular programmes worked (Lavis and Wilson, 2011). Similarly, Owczarzak's study concluded that barriers to implementation of evidence-based interventions by community based organisations may be related to the lack of attention in such evidence-based interventions to the experiences and knowledge of CBOs themselves, their staff, and their clients (and staff knowledge of their client's needs), and that developing implementation guidance that is more population and contextually sensitive would be valuable (Owczarzak, 2012).

3.2.2 Facilitators to research use and knowledge mobilisation

Several studies identified similar facilitators to research use and knowledge mobilisation (Beddoes et al., 2012, Jack et al., 2011, Kimber et al., 2012, McLaughlin et al., 2010, Ramanadhan et al., 2012). These concerned developing relationships between academia and TSOs, technical guidance or assistance in implementation (in the form of manuals, or experts), clear leadership, interdisciplinary working, improving access to research of different kinds, evidence of similar organisations that had successfully implemented the evidence-based programme and more relevant local research.

Ramanadhan's study found that linking with 'technical assistance' (such as programme architects, researchers and funders) to help deliver the programme, and to set outputs and outcomes, was seen as beneficial (Ramanadhan et al., 2012). Strong relationships were developed through more participatory approaches to conducting research. In particular, they noted a need for research to include CBOs so that the community context is understood as an important factor in any intervention (rather than seen as a variable in need of 'controlling'). Similarly, in McLaughlin's study, when respondents were asked

what would help the uptake of research evidence, more relevant, local research was highlighted as important, as well as greater understanding of the range of clients served by the organisation.

Kimber's study of the implementation of evidence-based practice found that respondents felt that clinical transformation was a 'thoughtful and intentional' process, needing clear leadership, and effective mechanisms for managing the project. Respondents reported the value of including a range of disciplines and representation from the geographical spread of the organisation as it created a varied perspective on implementation and its impacts. Similarly, Jack et al found that interviewees reported that senior support, individual skills development, along with an identified individual with responsibility and skills to locate and appraise evidence would facilitate research use (Kimber et al., 2012).

Beddoes' study of Open Access to scholarly research for third sector organisations found that facilitators of using research included: more freely available ways to access research (e.g. Google scholar); the importance of intermediary bodies in synthesising evidence and providing briefings for the sector; a repository for Third Sector research; finding better ways to improve the interaction and information sharing between academia and TSOs to make research more relevant to their decision making. Along similar lines, McLaughlin's study found that improving access, prompt publishing and dissemination, plain English summaries, easy to use databases and better organised and coordinated research were important to facilitate research use (McLaughlin et al., 2010).

Jack et al said that their interviewees felt that there needed to be evidence of successful implementation elsewhere and supported by expert opinion as well as the wider community partners. They also wanted evidence that met the stated needs of women using their services and could be implemented with minimal financial and human resource implications. They also found that if there was an endorsement of formal partnerships between universities and the organisations concerned, and if findings were clearer with guidance on how to apply them to practice this would also facilitate the use of research knowledge (Jack et al., 2011). Another Canadian study found that categorising systematic reviews by the determinants of health, or topics related to treatment, care and support for specific populations would enable more relevant results to be retrieved, and would increase the flexibility of searching (Lavis and Wilson, 2011).

3.2.3 Strengths of TSOs in knowledge mobilisation and research use

Two studies focused on the ability of TSOs to use research and other knowledge, rather than their inability. In Owczarzak's study (Owczarzak, 2012), the author argued that previous research on implementation of evidence-based interventions by CBOs had taken a capacity building approach, focussing on what an organisation *lacked* in order to faithfully implement a DEBI (Diffusion of Effective Behavioural Interventions) programme, and to a large extent ignored the values, mission, experiences, and views of the implementing organisation. Owczarzak was interested in finding out what other (i.e. positive) factors influenced implementation fidelity. The study found that CBOs recognised the value and importance of evidence-based practice for HIV prevention services, some even seeing it as central to their organisational mission and identity.

However, interviewees reported a conflict between what is presented as an intervention that 'works', and practitioners' own knowledge of their clients and what 'works' for them. Owczarzak found this created ambivalence amongst staff responsible for implementation toward the programme they were meant to be implementing. Furthermore, interviewees contested funder and programme designer definitions of effectiveness and what counted as evidence of effectiveness.

Wilson et al's survey looked more generally at what organisations were able to do when it came to using research in practice. They found that approximately half of the organisations surveyed felt they had the capacity to apply research, and more than half felt their organisational culture supported research use. Organisations also reported being strong at finding research through networks, websites, and in grey literature.

3.2.4 Motivations for knowledge mobilisation and research use

Third sector organisations reported using research in order to access a range of benefits such as improved services for clients, positive impact on staff, increased confidence in negotiating with funders and avoiding implementing programmes which do not work. For others, using research was a funding requirement. Kimber's study of the process of implementation of a number of evidence-based practices in a large community based provider of child and adolescent mental health services in Canada found that changes brought about by the transformation process were seen as beneficial to clients, and outweighed the disadvantages (Kimber et al., 2012). The perceived impacts of implementing evidence-based practice included increased confidence amongst practitioners in practice skills, and increased confidence in their employing

organisations as a leader in healthcare service provision (Kimber et al., 2012). In Lavis and Wilson's study, which explored the use of systematic reviews by community based organisations, they found that when participants were told what a systematic review was, they felt it would be of use to their work, in terms of being assured that all relevant research had been included, avoiding the delivery of ineffective services or interventions, and enabling constructive debate with stakeholders on what interventions were useful (Lavis and Wilson, 2011). Ramanadhan et al found that implementing evidence-based programmes was important to organisations external to the CBO (such as funders, national agencies, researchers), and can be mandated by them in order to receive funding to provide services (Ramanadhan et al., 2012).

3.2.5 Processes of knowledge mobilisation and research use

Dolcini's study looked in depth at the process of implementing an evidence-based intervention. They used the ADAPT framework, based on Rogers' Diffusion of Innovations theory (Rogers, 2005), which describes a series of phases in intervention implementation (assessment, preparation and implementation) and conducted interviews with members of staff responsible for programme implementation across agencies funded by the Centers for Disease Control that were implementing an HIV/AIDS Diffusion of Effective Behavioural Interventions (DEBI) programme (Dolcini et al., 2010). The study found that consultation with external stakeholders was done rarely and normally after a choice of which intervention to implement had already been made.

Organisations often chose interventions without considering their specific skills and capability to deliver the intervention(s), and staff tended to be initially unfamiliar with aspects of the intervention (even after it had been selected for implementation).

Preparation for the intervention normally included recruiting new staff, however, problems with staff retention meant that organisations frequently returned to earlier stages in their implementation process to re-train and induct replacement staff. The authors suggest one way to ensure more successful implementation and address some of the problems organisations encountered would be a two-phase funding process. In phase one, funding is released, and organisations assess the needs of their client group and select an appropriate intervention, and the second phase of funding is then made available for them to adapt and implement it.

In McLaughlin's study, interviewees reported that academic knowledge mobilisation was generally the role of one individual who would conduct literature reviews to inform funding applications or new projects, rather than for day to day work and decision making. The internet was also used to find information for decision making, being seen as an efficient way to get the information quickly (McLaughlin et al., 2010).

3.3 What are the implications of this research for the research community, as well as TSOs themselves?

This scoping review located ten qualitative or mixed methods studies that investigated how TSOs use research and other forms of knowledge in their work. There were only two studies conducted outside Canada or the USA. The organisations studied varied in terms of their size, client groups, expertise and resources. TSOs' existing understanding and use of research knowledge varied, and many of the studies focussed on exploring the different factors that facilitate and impede knowledge mobilisation. These included practical barriers such as costs of journal subscriptions, staff skills and time to search, access,

adapt and apply research to their organisational context and a lack of time for reflective practice.

A more philosophical barrier was a rejection of or ambivalence towards research that failed to take into account service user and staff expertise and knowledge. This echoes issues raised by a previous discussion of the challenges and opportunities of knowledge translation and exchange in community-based organisations (Kothari and Armstrong, 2011). As stated earlier, a particular strength of TSOs is that they are client- or community-led; however, in this review, only a few studies explored how this influenced knowledge mobilisation, or the different perceptions of what counts as “knowledge” for TSOs, even though these are likely to be critical in developing approaches to knowledge mobilisation that are effective for TSOs. What was found was that the primacy that TSOs give to the views, needs and wishes of their clients meant that research knowledge was sometimes seen as inappropriate as it failed to take account of these factors and the circumstances of their particular service users. The difficulty was how to adapt either the evidence-based intervention or how to integrate the research knowledge with practitioner and service-user experiential knowledge.

This philosophical barrier is reflected in existing debates as to what constitutes valid “knowledge” for service organisations (Nutley et al., 2007) and that TSO preferences for locally or internally generated evidence over externally produced evidence are only partly due to practical limitations (Kothari and Armstrong, 2011, Jack et al., 2011, Owczarzak, 2012). Potentially, the strengths of TSOs in partnership working is reflected by their preferences for using case studies, examples of good practice in similar organisations, and even expert opinion in decision making. In several of the studies, research

outputs were seen as not as important as these other sources. Potentially, the perceived “research-practice gap” mentioned by several studies demonstrates a potentially important point for developing research-use approaches with TSOs; if research is not seen as relevant to organisational culture and client, or local contexts, then it does not carry the same importance as other sorts of (experiential) knowledge. One implication is that experiential knowledge could be more fully acknowledged in knowledge mobilisation activities, and it follows that such experiential knowledge may then require criteria to judge its trustworthiness. Although whether or how this could be achieved is debatable, but is an issue picked up in the case study findings (Chapters 7-10)

In terms of the identified enablers for knowledge use by TSOs, freely available plain English research summaries or evidence syntheses could be very helpful, partly due to reducing the time needed to access and understand the evidence base. Links to external researchers and research organisations were also cited as important for similar reasons. The desire to inform and co-produce research was particularly evident and would go some way towards overcoming the philosophical barrier referred to previously.

There was less evidence on how TSO strengths in service redesign influence knowledge mobilisation. However, the two studies which examined the implementation of DEBI programmes raise an important discussion about the need for a more equitable relationship between TSOs and the “evidence base”; one centred on a mutual appreciation that without involvement in the design of effective behavioural interventions, TSOs may always “fail” to implement them faithfully. The multi-disciplinary contexts within which TSOs tend to work, the patchwork of funding they use, and the importance of service user views, means that interventions are likely to be adapted before implementation. This

may indicate a need for interventions which are more open to adaptation without losing their active mechanisms. Research using theory driven approaches, such as realist evaluation or review may offer a more appropriate approach to evidence-based programme design, implementation and evaluation activity (Pawson et al., 2005b).

There seems to be a paradox between organisations knowing that using research is important to their organisation, whilst at the same time rejecting research too. Some of the reasons for this have already been suggested through the scoping review (research valuable or essential for negotiating in funding relationships, however a-contextual nature of some academic research and lack of incorporation of staff and client knowledge undermines the reach of research in TSOs), but in terms of understanding whether the findings from the scoping review are representative of the wider third sector, more research is needed.

3.4 Limitations

The relatively small number of included studies means that at this point a full systematic review is probably not warranted. Most of the research was qualitative; there were few studies from the UK or Europe, and relatively few on TSOs working in key service areas such as mental health, addiction or child welfare. It was not always clear whether an organisation was a third sector organisation according to the definition, due to cross-national differences in language and a lack of information about the official legal status of the organisations. During screening, attempts were made to ensure that the included studies met the definition of third sector organisations. For instance, social enterprises (a type of business set up to achieve a social purpose) were

not included in the definition of the third sector but studies of such organisations may have been included unintentionally.

Conclusion

This review identified a small body of literature concerning how TSOs mobilise research and other types of knowledge. The findings indicate that TSOs do use research knowledge in their work, but they appear not to privilege research above other forms of knowledge (experiential or client informed). In terms of process, there also appears to be a preference for collaborative, relational approaches to knowledge mobilisation. Third sector organisations often face financial constraints, as well as personnel time constraints which, added to the a-contextual nature of much research output, means that accessing, adapting and applying research knowledge in their work may be challenging. When research conflicts with organisational culture, there is a preference for organisational culture, which implies that such embedded, cultural ways of working may require other sorts of “knowledge” and different strategies for implementing research-based practices into these types of organisations to inform them. Although many of the reported barriers to knowledge mobilisation may be shared with other kinds of organisations, this review suggests that because of the external, contextual and internal cultural features of most third sector organisations, the barriers may operate differently and impact differently.

Chapter 4 Assessing research use in UK third sector healthcare organisations: using cognitive interviews to pilot the Canadian "Is Research Working for You?" self-assessment tool

In the previous chapter, the scoping review introduced a series of issues which indicated some of the potential themes in how and why third sector organisations use research: TSOs have their own distinctive knowledge, consisting of service user and staff experience, and this is an important source of knowledge in their decision making. Their use of research-based knowledge seems to be related to funding their organisations, and the source of the knowledge, or what kind of knowledge it is seems to be important (case studies, local examples, service user or staff knowledge), so if research is not seen as relevant to organisational culture and client, or local contexts, then it may not carry the same value as other sorts of (experiential) knowledge.

This Chapter reports on the findings from a pilot survey which used cognitive interviews to determine whether a Canadian research-use self-assessment tool would work as a survey instrument in the UK. The chapter builds on the themes from the previous chapter by grounding them in the direct experience of people who work or volunteer for third sector healthcare organisations. In 4.1 the background for the pilot survey is given, and it is put within the context of the PhD. In 4.2 the methods of the pilot survey are shown. In 4.3 the findings of the cognitive interviews are given in relation to how clear and relevant the tool is to TSOs and 4.4 the focus moves to a broader analysis and the questions raised by piloting the survey tool. The interviews were rich, both in terms of how well the self-assessment tool would work as a survey instrument and also in terms of the attitudes and beliefs TSOs volunteers and staff hold in relation to

research and research use. In 4.5 the findings of both analyses are discussed in relation to the emerging themes from the scoping review and the strengths and limitations of the study are given.

4.1 Background to the pilot survey

The scoping review in Chapter 3 had established that knowledge use for TSOs is a complex, context dependent process, influenced by factors beyond the quality of the knowledge itself (its provenance, clarity and applicability) such as the existing knowledge and individual judgement of the knowledge user, the contexts within which they work, and the prevailing policy and political climate (Hammersley, 2013, Gabbay, 2011, Weiss, 1979, Best and Holmes, 2010, Davies, 2008b, Davies, 2015, Hardwick et al., 2015). Different people within an organisation are likely to experience the processes of knowledge use differently, and this is likely to be different between different kinds of organisations.

The scoping review indicated how the contexts within which healthcare TSOs work may inhibit research-based knowledge mobilisation (such as lack of funding for academic journal subscriptions or how the holistic approaches TSOs favour do not correspond well to a research literature structured around medical specialties), so I wanted to look in greater depth at how healthcare TSOs use knowledge (Hardwick et al., 2015). With this in mind, the overarching aim of the next study was to investigate the current self-assessed activity levels and capabilities of research and other knowledge use within third-sector healthcare organisations in the UK.

To do this, I chose the "Is Research Working for You?" (IRWFY) self-assessment tool as the starting point (Park et al., 2014). This was because the IRWFY tool was developed primarily for healthcare organisations, but has since

been used with community-based organisations, and subsequently used successfully with a wide range of organisations (public and not-for profit) in Canada and internationally (Thornhill et al., 2009, Kothari et al., 2009, Wilson et al., 2011b), in which it was shown to be user friendly, have good content and discriminant validity, and strong response variability. This means that the tool measures what it purports to measure, that it can distinguish between organisations that have the capacity to use research and those that do not, and between those that do use research and those that do not. The tool invites respondents to score on a Likert scale the extent to which they agree with statements across four domains pertinent to research use – how they acquire research, how they access it, how they adapt it, and how they apply it. See Figure 3 for an example of a question.

The tool has been revised several times since its inception in 1998, and the present version is available online². The version I piloted was prior to this one and is now unavailable online but a copy is included in Appendix 4. The questions are the same, as are the introduction and discussion sections; the only change is the font, layout and formatting.

Although developed as a self-assessment tool, it has previously been used as a survey instrument in Canada, (Wilson et al., 2011b); so to test out whether and how it could be used as a survey instrument, and to adapt it for use in a UK context, cognitive interviews were used (Willis, 1999) to pilot the IRWFY tool with a sample of TSO leaders. During a cognitive interview, participants from the population of interest are given a copy of the survey and, with guided

² <https://www.cfhi-fcass.ca/Libraries/Documents/SAT-Self-Assessment-Tool.sflb.ashx>. [accessed on 6 December 2018]

prompts from an interviewer, invited to ‘think aloud’ as they complete the questions. They are commonly used in piloting surveys to detect inconsistencies, assumptions and difficulties with language and comprehension that can be rectified before the survey is implemented.

| <i>4.2 DO OUR DECISION-MAKING PROCESSES HAVE A PLACE FOR RESEARCH?</i> | | | | | |
|--|---|---|---|---|---|
| RATING | | | | | |
| 1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree | | | | | |
| When we make major decisions, we usually allow enough time to identify researchable questions and create/obtain, analyse, and consider research results and other evidence. | 1 | 2 | 3 | 4 | 5 |
| Our management team evaluates the feasibility of each option, including potential impact across the organization as well as on clients, partners, and other stakeholders. | 1 | 2 | 3 | 4 | 5 |
| Decision makers in our organization give formal consideration to any recommendations from staff who have developed or identified high-quality and relevant research. | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders know when and how major decisions will be made . | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders contribute evidence and know how that information will be used . | 1 | 2 | 3 | 4 | 5 |
| Staff who have provided evidence and analysis usually participate in decision-making discussions . | 1 | 2 | 3 | 4 | 5 |
| Relevant on-staff researchers are made part of decision-making discussions . | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders receive feedback on decisions, with a rationale for the decision. | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders are informed of how available evidence influenced the choices that were made in our organization. | 1 | 2 | 3 | 4 | 5 |

Figure 3 Sample questions from "Is research working for you?" tool

Aim of the Pilot Survey: Is the Canadian "Is Research Working for You?" self-assessment tool a clear and relevant series of questions which could be used as a survey with healthcare TSOs in South West England?

4.2 Methods

Sample and recruitment

I was keen to interview respondents who worked in Third Sector healthcare Organisations in our intended survey area, and as my PhD is funded by the UK National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care in the South West Peninsula (NIHR PenCLAHRC) the sampling frame consisted of healthcare TSOs across the counties which make up South West England (Devon, Cornwall and Somerset). I chose eleven organisations to take part in the cognitive interviews from local third sector healthcare organisations. The organisations were some of those contracted to provide NHS services, and chosen to ensure there was representation from small and large organisations (based on financial turnover, staff numbers). Across the organisations, I spoke to staff with a range of roles (Regional managers, Chair, Trustee, Chief Officer, and Senior Manager).

These eleven organisations were invited via email to participate in the study. A copy of the participant information sheet and a consent form was attached to each email (see Appendix 5), and I offered a telephone call to explain more about the study and answer any questions. Of the eleven organisations invited, seven responded positively and were interviewed. For characteristics of the participating people and organisations, please see Table 3.

Ethics

Ethical approval was granted from the University of Exeter Medical School Ethics Committee (Ref: Feb15/B/060).

Table 3 Characteristics of participants

| Int ID | Who answered the questionnaire? | Main business | Organisational Form* | Annual income** | National or local organisation |
|---------------|---|--|--------------------------------------|------------------------|---------------------------------------|
| ID01 | Director | Homelessness prevention | Company Ltd by Guarantee and Charity | £360,000 | Local |
| ID02 | Chief Executive | Advocacy and support services for people with disabilities | Company Ltd by Guarantee and Charity | £1.5m | Local |
| ID03 | Chief Officer | Mental Health Promotion and Care | Company Ltd by Guarantee and Charity | £840,000 | Local, affiliated to a National body |
| ID04 | Acting Associate Director, Southern Region. | Mental Health Care, advocacy and support | Company Ltd by Guarantee and Charity | £39.01m | National |
| ID05 | Chair of Trustee Board | Local Infrastructure Services for voluntary and community organisation | Company Ltd by Guarantee and Charity | £193,000 | Local |
| ID06 | Services Manager | Dementia Support | Company Ltd by Guarantee and Charity | £90.6m | National |
| ID07 | Chief Executive | Employment and support services | Social Enterprise | £1.476m | Local |

* according to governing document

** Based on last accounts filed with Companies House/Charities Commission

Data collection

I conducted the cognitive interviews face to face, either at the University of Exeter, the respondent's office, or a suitable private location elsewhere (e.g. in the person's home). During the interview, respondents worked their way through the whole tool (introduction, questions and discussion) as if they were answering it on behalf of their organisation and were invited to vocalise what they were thinking and feeling about what they were reading, how they understood the text, and how they would answer. The interviews typically lasted a little over an hour (average 73 minutes). All interviews were digitally

recorded, and notes were taken. The recordings were transcribed by an external transcription service. I listened to the audio recordings and checked the transcriptions for accuracy and to remove identifying features of the respondent (e.g. names, places).

Data analysis

The four domains of the tool (Access, Acquire, Assess, and Adapt) were used initially to organise the data during analysis. I read transcripts and summarised the data onto a table divided into the four domains. I then re-read the table and sorted the data into whether they related to the clarity of the tool's questions, or to its relevance to the respondent's TSOs.

I completed the data analysis and one of my PhD supervisors conducted random cross-checking on two interview transcripts to check interpretation and improve the trustworthiness of findings. Disagreements were resolved through discussion.

4.3 Findings

Summary

In terms of how clear and easy questions were to understand, respondents identified the following issues: the overall concept of "research use" was not readily recognised; the language and tone of the questions were not always easy to understand; question phrasing and the structure of the tool could both be improved. In terms of how relevant the questions were to their organisation, and therefore how straightforward it was to answer them, respondents felt it was worthwhile to ask about research use but that the process of research use, as outlined, was not recognised or did not fit with what they did. Respondents also

felt the questions implied that there was a "correct" way to use research and that this was at odds with what they did. For example, they commented on the lack of consideration in the tool of knowledge from service-users and in-house evaluation work and also on how their organisational context influenced the process of research use.

4.3.1 Clarity

The concept of research use not readily recognised

The tool's implied process of research use and its relevance to respondents is discussed in section 4.3.2, but for respondents to make a judgement about the relevance of the questions to them they needed to understand the overall aim and purpose of the tool first. The concept of "research use" was unfamiliar and unclear to some respondents at first and this presented initial difficulties in understanding the purpose of the survey. One respondent commented that "gathering and using research [...] just seems like a huge concept [...] it seems a little bit overwhelming" (ID02). The four domains of the tool and the questions in each domain against which respondents scored themselves outlined a process of research use but it took time to understand this, with some respondents not feeling that they understood until they were in the final domain.

Language, interpretations and tone

One reason for doing the pilot interviews was to ensure that the tool would be free from confusing or unclear terms and easily understood by a UK audience. Respondents noted the jargon in the tool but did not think this hampered their comprehension. They attributed this to their own knowledge and experience of

reading Government policy documents from the UK that also contain confusing terms.

Nonetheless, there were different interpretations of some key words in the tool, such as "grey literature", "decision makers", "policy makers" and "research".

For example, there were three different interpretations of who "decision makers" might be – those within the organisation (Board of Trustees/Governing Body), local commissioners of services, and national policy makers. As the tool did not define who "decision makers" were, and as each of these different groups could justifiably be called "decision makers", the question was left open to individual interpretation. Respondents found words like "corporate" and "rewards" in questions off-putting. Respondents interpreted these as an overtly business-like/private sector language which was not congruent with their ethos as charitable organisations. For example, in relation to a question that asks how the organisation rewards staff for being flexible, one respondent commented "[...] it's not about rewarding staff, it's about what is right for the service and for the service user somehow and the word reward just doesn't gel for me in that respect." (ID06). The question was actually not about remuneration, or pay bonuses, but was about whether the organisation led by example in using research (Q 4.1.6), and so in this instance, the respondent entirely missed the point of the question, and instead found themselves referring to their organisational culture and ethos to contextualise it.

The central concept of research was also contested, with varying definitions.

Respondents described their own organisation's monitoring and evaluation work as research, or described their organisations as evidence-based, and talked about the research they did. However, there was recognition that this was

different to the kind of research that academics did in Universities leading to one respondent thinking aloud that "it's [the tool] asking very black and white and it hasn't broken down research in terms of more lower level stuff, so I'm still on academic, high convoluting stuff, [...] I might decide that we do do a little bit of research but my automatic instinct is just to say strongly disagree to the lot [all the statements about using research], which if I step back, is probably not true but that's my automatic response to it." [ID02] This kind of response, which respondents perceived as downplaying the knowledge generated within organisations because it did not fit with their perception of what the tool means by "research", meant that they could not relate to the questions and found it difficult to complete.

When it came to the overall tone of the tool, issues were raised that it sounded 'academic' and too 'high level'; that some questions were leading, inviting respondents to agree with a 'right' answer; that questions implied a positive answer was expected so that some respondents spoke of feeling guilty or fearful of what their negative answers meant about the professionalism and quality of their organisation. One respondent, in relation to Question 4.2 (on the place of research in their decision making) said:

[reading question] "Staff and appropriate stakeholders receive feedback on decisions with rationale for the decision", you sort of feel like all these questions want you to say you strongly agree. They're the right answers. I sort of know in my heart that these are the right answers and that I'm supposed to put strongly agree and I'm struggling because I don't know that I can, because I don't know what the [...] I think these are the right answers and so if I'm feeling lazy, I could just go all the way down. [reading the next question] "Staff and appropriate stakeholders are informed of how available evidence ..." you know, I just feel like they want me to be saying yes, we do all these things and if I say yes, then that's the right answer. (ID02)

Phrasing and structure

Questions needed reading and re-reading as respondents attempted to understand what it was they were being asked, leading to frustration (with themselves and the tool): “is it just me? Am I being thick? I don’t get that question.” (ID02). Respondents suggested that using examples to illustrate particular questions would improve comprehension. Some of the questions in the tool were thought to be repetitive and long, which made them difficult to follow. For example, some questions have several points for the respondent to consider such as this example from Part 3 of the tool (on Adapting research):

“Our organization has enough skilled staff with time, incentives, and resources who use research communication skills to synthesize in one document all relevant research, along with information and analyses from other sources” (p5). Respondents reported there were too many criteria in this statement to answer positively to, and so whether or not they met some of the criteria was felt to be irrelevant, because they felt they would have to answer negatively.

The structure of the tool follows four sequential domains or stages of research use (Access, Assess, Adapt, Apply), with questions being asked of respondents under each heading. One respondent felt that the order did not make sense, with questions about what they felt to be the most important aspect (Apply) coming last, which they then pointed out would be when the respondent would be most tired and unwilling. In addition, respondents noted a lack of space to provide commentary on their answers, which was felt to be frustrating as there were contextual issues which some felt they would like to be able to give to explain why they had answered negatively.

4.3.2 Relevance

Worthwhile to ask about research use/ purpose of the tool

Respondents were interested in the purpose of the tool, and in being asked questions about their own research use. Organisations that self-identified as being 'evidence-based', by which they meant they conduct their own evaluations, welcomed being asked questions about how they used research in their work. Although some found the introductory section unclear, others thought it worked well in setting out the purpose of the questionnaire, as illustrated with this comment from one respondent "I'm thinking it seems to make sense so far, I don't have any problems with it, seems like a reasonable premise actually." (ID04)

The process of research use not recognised or implies a right way which is unknown to respondent TSOs

In the same way that the concept of research use was unclear at first, the process of research use outlined by the tool (that research is accessed, acquired, adapted and applied) was not clear, and when understood (or explained to them by the interviewer), was not seen as relevant to respondents' experiences of how things worked in their organisations. This feedback was explored further with the data in terms of how organisational contexts influence research use, in particular, the place of service users' voices and experience in research use and the place of internally generated research and evaluation.

The place of service users' voices and experience in research use processes

One respondent felt strongly that they could not relate to the process outlined by the tool because it did not consider incorporating service users into the

research-use process, something that was essential to how their organisation worked. She commented:

[...] a lot of our research is service-user led, user-led research, this doesn't cover that at all really, so I haven't answered a single question based on that, so we do lots and lots of what do people want, they feedback, we build in, then we might look at the literature so that's the process we tend to use, it's user led, (ID02)

Interestingly, what the respondent above describes is a form of the tool's assumed process of Access, Assess, Adapt and Apply, but one that draws on wider sources of knowledge. In addition, respondents volunteered further examples of other sources of knowledge for their work (such as briefings from their national organisation or evaluation work conducted in-house.)

ii) Organisational context and the process of research use

Respondents could not relate to the "typical" kind of organisation that they felt the tool pre-supposed they would be; the way some questions were worded was thought to imply an unrealistic view of what it was like to work in or run a TSO. For example, Part Three, Adapt, Q1 asked whether the organisation had "enough skilled staff, with the time incentives and resources who use research communication skills to a) Present research concisely and in accessible language; b) Synthesize in one document all relevant research with info and analysis from other places; c) Link research results to issues facing decision makers; d) Provide answers to decision makers"

Respondents found it difficult to relate to this and answer if their organisation was not at a size or complexity where there were skilled staff, suitably incentivised and resourced, to do research work. This assumption, that there was a designated research function within the organisation that could routinely be called upon to support decision making, cropped up elsewhere in the tool

and made the questions difficult to answer. This quote illustrates such respondent views,

[...] my type of organisations, the given is we don't have enough skilled staff, they don't have any time, very few incentives and barely any resources, we make incredible things happen with nothing, so the automatic answer to that bit is no. (ID03)

In addition, some commented that the tool was not rooted in everyday experience, that it was idealistic, or that it was too strategic:

I haven't got, I'm totally confused, I am totally, well, I tell you what I feel, the people who wrote it are very, they've been in academia for the last 30 years and they are steeped in that world, that's who wrote it. It was maybe designed for those kinds... and I'm thinking it's really designed for research organisations rather than organisations that this is part of what they do. (ID02)

The lack of time within organisations to consider research when making decisions meant questions about how this happened appeared idealistic, echoing again a process of research use that was alien to interviewees. One respondent, thinking aloud about a question on using research evidence in decision making (Q4.2.1), reflected that:

Yes, because you'd want to add some narrative to that, that would say often we have to make decisions and they might be major decisions, quickly and swiftly; we don't have the time because we're in the real world. It is idealistic because inevitably, where you've got enough time, you would always consult that research and say "We made this decision based on this" but often we have to go "We made this decision because it seemed the right thing to do at the time" or "because we had to, quickly". (ID04)

iii) The place of their own research and evaluation in the tool

Respondents conceptualised research in different ways and there was a tendency to see it in terms of their own evaluation work, or work they did for commissioners (monitoring data) on existing contracts, or to secure future funding, rather than academic research, generated by an external organisation.

You see, this is somebody else collecting... now you see, I've been looking at this, that this is us carrying out the tasks, we've got a job to do, we're doing it, we're evaluating how we're doing, we're researching it on the way. [...] But this is [the tool] not connecting with anything in my life. (ID05)

If an organisation did have staff with a dedicated role for assessing or using research, or the organisation conducted its own research and evaluation, the tool was felt to be more relevant to their work.

4.4 Broader analysis of the meaning of research

During the analysis, as I re-read transcripts and thought about what was being said, I realised that alongside this data answering my questions on the tool's clarity and relevance, respondents were also providing answers to my overarching questions to do with how and why third sector organisations use knowledge in their work. I decided to analyse the interviews again, using the following questions which I had developed from my transcript reading:

- what is research?
- processes of research use (e.g. how is it accessed; barriers and facilitators);
- how does research get done? (Who 'does' research stuff in the organisation? e.g. own staff, trustees, volunteers, no one, contracted out);
- why do they use research/ do research? / not use it? (e.g. for funding applications, as part of their role);
- what resources do they have for research? (e.g. time, people, money, contacts, how is it funded?);

- what other knowledge do they use? (e.g. audit, grey literature, staff/service user experience)

And finally, a heading which included "anything else? / Contextual issues".

I created a chart which had columns to capture interview data on these questions, and so I re-read the transcripts with these questions in mind and summarised the interview data under the appropriate heading. Not every respondent had covered every question, but reading down the columns, to see what respondents felt overall about these questions led to the findings in 4.4.1-4.4.4.

4.4.1 What is research?

The original tool talked about research and defined this as "one of many sources of information and data used in making decisions. In particular, health services research can help to: explain the need for certain decisions; show the reasons for choosing one of many competing arguments; increase confidence in decisions that are made; and help build consensus" (p3) In the interviews, respondents gave their own explanations of what research is, and what it means for them. These included research being the process of gathering and interpreting information, calling research rigorous and validated knowledge. Others defined it as published work which concerns effectiveness and what works or does not work. One person felt that 'research' was clinical and academic language, focused on 'curing' people from health problems.

Doing research was thought of as a skilled activity, because of how it is approached, reported and delivered. Some said doing and using research was part of organisational culture, and concerned understanding what they were

doing, and how effective they were, often motivated by wanting to generate income from commissioning or grant making organisations. Others felt research was not what they did, which they felt was less rigorous, and instead that it was other worldly, or otherwise inappropriate for their work, and that it existed at a different, higher level. Some felt the word research was focused too much on an academic understanding, and that there should be room for alternative words like evidence or monitoring which were felt to be more congruent with their organisational culture, as reflected in this quote.

[...] as an organisation locally, research isn't really something that we refer to. We do have a research network of volunteers and people who do things, but it's kind of outside the remit of what we do. But I was suggesting to you that actually we do a lot of evaluation of our services, which is kind of research and falls within that remit. (ID06)

4.4.2 Process of research use

In responding to the self-assessment tool, respondents tried to relate it to the processes of research and knowledge use that they did do within their organisations. The processes they described were informal, and ad hoc rather than an intentional, strategic incorporation of research-based knowledge into decision making. The kinds of activities they did to use research included reading websites or magazines, talking to peers, or conducting and then action-planning surveys of staff and service user views. Some of the respondents that I spoke to worked for organisations that were a branch of or affiliated to, a larger national organisation which had a research and policy function, and so their processes of research use would also include reading reports from their national body. However, there were problems with this approach: there was not always time to read the reports, consider what they meant for practice, and then

implement change and the reports could be too conceptual and so unhelpful in directing local implementation anyway. Overall, it seemed as though processes for research use were opportunistic, rather than planned and integrated with organisational processes.

A few spoke of research use processes in relation to funders, and how research would be used by default if a commissioner contracted them to provide an evidence-based service. However, one respondent spoke of the difficulties encountered when they knew something their commissioner was asking them to implement was potentially ineffective. "I'm just about to implement the recovery tool which actually I'm being told that recent research has found isn't very effective but it's what the commissioner wants, it's the latest fashion, so we're implementing it." (ID03).

This respondent went on to explain that whilst they would like to involve staff more in using research in decision making, it is irrelevant as they are there to deliver a contract.

But yes, I do try and involve staff but we're working with our hands tied behind our backs, so quite often I don't want to raise unrealistic expectations, we need to provide what the commissioners want us to provide and in this current era of not very much money, nobody wants to take risks so nobody wants to do anything new, even though the research might tell you that that would be the best way of working with it. (ID03)

The reference to risk, and following the wishes of the commissioner, despite misgivings points to a larger issue to do with the role of commissioners and funders in research use by TSOs (which is explored in Section 4.4.4). It also indicates a question as to the degree of organisational autonomy that TSOs have and the extent to which TSOs are able to direct their own work and are

empowered to do so. TSOs that are concerned about losing contracts (or funding) may tend towards being risk-averse, and doing what they're told, regardless of the evidence. Other TSOs might not feel that the cost of delivering ineffective services is worth it, and so might either change what they do or refuse/terminate the contract. Either way, this indicates an interdependent relationship between effectiveness, knowledge and funding.

Related to processes of research use were responses about how research gets done in the organisation, and whether or not there was a dedicated role or person that did research. Respondents from two organisations reported that they did have a dedicated role for research, but in one of those organisations, this was going to be discontinued due to funding constraints. In the other organisation, the person currently fulfilling that role was about to go on maternity leave, and it was not clear whether they would be replaced temporarily, again due to funding concerns. In most organisations though, there was not an identified member of staff tasked with either conducting research within the organisation, or with finding relevant knowledge (research-based or otherwise) and bringing it into the organisation. Some respondents thought that research was not a designated role, but was part and parcel of everyone's work, although this was research in the sense of all staff having responsibility for gathering data on key performance indicators, rather than necessarily starting with a researchable question and proceeding to use research methods to understand it. Other respondents thought that if staff were doing research then clearly, they did not have enough of their own work to do, and that should be looked into! These differing views point again towards the interrelationship

between research and funding, and to how differing definitions of research influence how research is constructed and used.

4.4.3 Why do they use research/ or do research? How is it resourced?

Respondents talked about a range of different purposes and outcomes that they were seeking when asked about their motivations for using research. They would evaluate their own services and use that research to either validate what they were already doing or to improve services for their users. They used research in a range of ways to convince and persuade funders, thinking that using research demonstrates you speak the same language as the funders; it shows you care about quality, that you are intelligent and that what you do is effective.

the important thing for [name of organisation] is how we use it, whether it brings us in any money, whether it influences our approach (ID02)

But I think even at a local level and a smaller level, even if we're responding to tender opportunities and we want to write why we want to take an approach that we take, we might want to put, "and research tells us to do it this way" and if we can link to a piece of evidence then that's helpful, (ID04)

Respondents talked of using research in campaigning and advocacy, to raise awareness of an issue and to raise the profile of their organisation as a solution to the issue (and in doing so, to potentially secure funding). Respondents referred to how they were operating in a competitive market, so the purpose of using research was to influence commissioners and secure contracts in whatever way possible. There was a view that research signified something important to funders and they needed to use research to be taken seriously. In this context, 'use' meant cite research in funding applications, or produce service evaluations. In this way, it appears that a key motivation for using

research is to validate or back up what is already being done by the organisation, rather than using it directly to provide advice and guidance. In this way, research takes on the quality of being the 'truth' of an organisations effectiveness and worth, used to 'prove' their trustworthiness and usefulness. The knowledge needed to guide and advise for decision-making seemed to be sought from more local knowledge, or from peers, staff and clients.

However, finding resources for research was problematic. Only two organisations had historically funded research roles, so for most, creating and using research was something which occurred alongside the day to day running of the organisation. There was a concern as to whether spending resources on research would be seen as a luxury that was diverting funding away from service delivery. One respondent put it like this "I wouldn't want to be seen as an organisation that isn't using the money to support people." (ID07)

Third Sector Organisations are funded through a mix of grants, legacies and other gifting from the general public directly, and from winning tenders or contracts to provide services, often on behalf of public sector commissioners. Many TSOs run several projects, funded from different organisations, and each of these projects will pay a proportion of their value to the 'core' of the TSO to enable it to exist: it pays for infrastructure (managerial and practical) which enables the project to work through giving it a physical location, an organisational structure and accountability, mechanisms for paying staff, managing rotas and volunteers and so on.

The proportion of funding which is taken from project funding (i.e. direct service delivery) and diverted to core costs and activity has to be rigorously accounted for and justified. Respondents seemed to think that resources for research sits

within core activity, rather than as a separately funded 'service', and so the difficulty in resourcing research depends on whether the organisation thinks research, and using research is enough of a priority to warrant being included as a core cost. Furthermore, research and research use also then depends on the extent to which the organisation prioritises doing and using research above other 'core' functions, such as having a Chief Executive, or staff training and development or a Human Resources Department.

Two organisations reported that they had purposefully built in funding for research to the contracts which they went for, but they added that this additional cost was not always understood or appreciated by local commissioners who instead felt that money for service delivery was not being used on service delivery. In the example below, where part of the funding from the contract was going to the national organisation (and would contribute towards the research and policy work of the national organisation), the value that being part of a national organisation brought to local service delivery needed to be made clear.

[...] for our organisation, we get challenged by commissioners and funders at a local level who say, "If we're giving you two hundred grand to provide services to people that live in [town], then that's where we want to see the money spent, we don't want to see a little bit of it filtering away to go and pay some of your academics in London to do a bit of research because we're not interested in that", so sometimes we have to have that argument with commissioners about our management costs, what that all boils down to, where it goes, what difference it makes and that's quite hard sometimes. ID04

Whilst there are strong motivations to want to do and use research, respondents were ambivalent about whether or not that could happen because of how resourcing research competes with other parts of the organisation for priority.

4.4.4 What other knowledge do they use?

Respondents used a range of different kinds of knowledge aside from research-based knowledge. They spoke about going to conferences to learn, participating in networks and partnerships and talking to peers and commissioners as valuable ways to increase their knowledge. The knowledge that staff had was accessed through team discussions, and client knowledge was used either through satisfaction surveys or through individual assessments and ongoing care planning. There was some resonance with the findings from the scoping review about using client knowledge in different ways to understand whether or not treatments or approaches were effective and going to be acceptable. "Client reactions to things, so you might put a tool down, assessment tool and they might, their physical reaction to it might suggest to you whether it's going to work or not." (ID03)

This focus on the person, on the client or end user of the services was a thread which ran through the respondents answers: talking about the absence of service user experience and views (or knowledge) in the tool, framing answers to questions in terms of how they related to the person, using people's lived experience and needs as the lynch pin for understanding and answering the questions.

4.5 Discussion

During the interviews, respondents were thoughtful about their organisational practice around knowledge mobilisation and were reflective on how they could use research differently and how different they felt the ways in which they used research were from those supposed in the tool. They demonstrated a

willingness to be more able to use research and other kinds of knowledge.

They had clear goals for research use, such as demonstrating effectiveness to commissioners of their services for funding purposes or raising the profile of their organisation.

Some healthcare TSOs want to be evidence-informed in what they do, and they recognise the value of systematically collecting and analysing data on the services they provide. Nevertheless, some of the barriers to research use for TSOs identified in the scoping review in Chapter 3 were also confirmed by respondents during interviews (e.g. lack of time to find relevant research, and of skills to assess its validity and applicability).

The interviews also showed that these healthcare TSOs vary in their knowledge of the academic research world (including its language, function, and rituals) and this affects how aware they are of research, how they access and appraise it, and how they use it. Healthcare TSOs are important healthcare system stakeholders, and as such, finding ways to include them more meaningfully in research is important. This can start with developing more mutually understanding and supportive relationships between research producers and healthcare TSO research users.

The findings also indicate that healthcare TSOs may interpret what is meant by research and knowledge differently to a conventional academic perspective on these issues, with people in healthcare TSOs offering divergent definitions of research, evidence, and knowledge itself. Despite these differences, it is clear that knowledge from staff and service users is foundational to healthcare TSOs; it is closely linked to their ethos and culture and to what may make them distinctive (Lang and Hardwick, 2016). Finding a way to capitalise on and

validate these kinds of knowledge could be useful for both healthcare TSOs and academics.

Research has many meanings attached to it; respondents said they were evidence-based if they used evidence they generated themselves but also felt this evidence was different – though certainly not inferior – to the research that academia generates. When this difference was articulated, it was in terms of "levels" and relevance; implying that academic evidence may be unrelated to local circumstances because it is at "too high" a level of generality, that it did not consider the local context, their organisation, or their service users (unlike their own internally generated knowledge). But at the same time, they did not always think their research and evaluation work was at the same level of quality as academic research, acknowledging the special set of skills necessary to conduct research. What was meant by 'higher level' was not explored during the interviews and is explored later in this work, alongside exploring the markers healthcare TSOs use to tell if research or evaluation is of "good" quality.

Potentially most importantly, the concept of "research use" as an activity and process did not translate well and felt at times like new territory to respondents. It is important to reflect on why this might be, and what it means. Following some personal correspondence with one researcher who has supported and developed the use of the tool, I wondered whether there has been significant activity to increase research use in Canadian healthcare systems for many years, and potentially this has had a trickle-down effect into wider, community-based organisations in Canada, whereas in the UK, formal efforts to increase research use are more recent and more limited to NHS organisations. It may be that the tool did not translate well because there is a time lag between what is

happening in the NHS around research use in the UK, and what is happening amongst healthcare TSOs in the UK. If this is the case, then it presents a timely opportunity to influence how those processes of knowledge mobilisation can be developed that are most suitable for third sector organisations as healthcare system stakeholders.

The third sector healthcare organisations I spoke to described some of the difficulties they experience in using evidence in practice (time, applying it to their work, access), but they hold these in common with other organisations and sectors. However, the interviews show that there is a contextual difference in how research is done and used which arises due to the way that healthcare TSOs are funded. Whilst it seems that those I spoke to felt that using research in funding applications is crucial to demonstrate their effectiveness and win contracts, research is not always prioritised as a core function and so rarely seems to have dedicated resources or a designated role. This is worth exploring in more depth, especially in terms of how resourcing for research competes with other organisational needs and how staff in healthcare TSOs place a value on research-based knowledge and in doing so prioritise it (or not).

Respondents valued the opportunity to think about research use in their organisation and that the introductory section for some set out clearly the purpose of the tool. But there were difficulties with the language, with tone and meaning, and with the structure of the tool itself. There were also perceived differences between the processes of research use outlined by the tool and those in the different organisations of the respondents, particularly to do with knowledge from service users and in-house evaluation work. Taken together, these findings suggest that the tool would not be useful for assessing research

use by TSOs in England without significant adaptation. This is in contrast to a Canadian study that reported the successful use of the tool in a survey with community-based organisations (Wilson et al., 2011b, MacGregor et al., 2013).

Where the tool has been used previously in a group discussion setting, it generated productive discussions about the nature of research and knowledge within the organisation, and provided space and focus for organisations to consider how they use research and how they might become more evidence-based (Kothari et al., 2009). In their discussion, Kothari and colleagues suggested a discursive approach may be more fruitful for organisations completing the tool, as it allows opportunities to develop "collective understanding resulting from the exchange of explicit and tacit knowledge". The intention was to see if IRWFY tool could be used as a survey instrument and the conclusion is that it is not suitable for that purpose, without significant adaptation.

Strengths and Limitations

This is the first study to pilot a research use self-assessment tool with a range of healthcare TSOs in the UK. In doing this, insights have been surfaced into the way that some TSOs conceive of research, how they conduct research within their own organisations, the importance and value of evidence to their work, and the difficulties encountered in using a self-assessment questionnaire as a survey instrument. The sample size was small and drawn from a range of healthcare TSOs in three counties in England, so further work would be needed to explore how these themes are relevant to other healthcare TSOs. Also, had interviews been conducted with people in different roles and at different levels in the same TSOs, this may have also revealed additional conceptions and

perceived capabilities for using research and the feasibility of the tool for assessing this.

Conclusion

In this study, I piloted a self-assessment tool to assess its suitability for use as a survey instrument that could provide a baseline of research and knowledge use amongst healthcare TSOs in the UK. There were difficulties with the language, with tone and meaning, and with the structure of the tool itself. There were also perceived differences between the processes of research use outlined by the tool and those in the different respondents' organisations. Also, because the instrument implicitly focuses only on the use of externally produced (e.g. academic) research, it does not capture or give value to other forms of knowledge (e.g. of staff or service users) or other evidence (internal service evaluations and performance monitoring) that inform the work of TSOs.

These are important findings and so instead of going ahead with a survey, I decided to direct the research towards understanding in greater detail and depth how and why third sector organisations use research by exploring with them the meanings and experiences they have of research in their own settings and on their own terms. To do this, I carried out two ethnographic case studies of mental health third sector organisations. In the next chapter, (5), the findings of this pilot survey and the scoping review are brought together to develop programme theory. The programme theory developed in Chapter 5 then provides the basis for case selection of the case studies (which is discussed in Chapter 6, Ethnography Methods) and was used as a guide to enable me to focus the work in the ethnographic studies (reported in Chapters 7 and 8).

Chapter 5 Initial explanations of how TSOs mobilise knowledge

The purpose of this chapter is twofold: to consolidate the findings so far within an organising framework and to provide a series of sensitising concepts and initial explanations or candidate programme theories which are explored and refined further during the ethnographic studies (Chapters 7 to 9). I used the domains from the conceptual map of knowledge mobilisation, developed by Davies et al (2015) from their review (introduced in Chapter 2, p30), as an organising framework. I populated each domain with relevant findings from the scoping review and pilot survey and each domain also included programme theories or further questions to explore in the ethnographic case studies. The domains are 5.1 Knowledge of all kinds; 5.2 Purposes and goals; 5.3 Connections and configurations; 5.4 People roles and positions; 5.5 Actions and resources and 5.6 Context.

In each section of this Chapter, I give a short explanation of the domain and how I adapted it for my research, followed by a synthesis of relevant findings from the scoping review and pilot survey, and then posit a series of programme theories or further questions for that domain.

In scientific realism, knowledge is accumulated on mechanisms of action: exploring how different contexts might influence their operation, and lead to differential outcomes. This is done through eliciting 'programme theory'. Programme theory is a term taken from evaluation research methods to describe the underlying reason for thinking that a particular intervention is liable to bring about the desired result. In realist research, the important aspect of a programme theory is that it pays great attention to mechanisms in action: a

programme theory from a realist perspective is three things: focussed on how a mechanism brings about change; cognisant of the role that context plays in that change and is middle-range. By middle-range, the intention is for the programme theory to operate at a level of abstraction which means that whilst it can speak specifically about the particular intervention in question, it can also be portable, and applied into other research questions/problems where the mechanism of action might plausibly be the same. Programme theories are the unit of analysis in realist research and can be expressed in different ways: as "if/then" propositions, or as explanatory sentences, or questions or diagrams.

If there was sufficient data to develop initial programme theories for each domain, these were written as 'If then' propositions. If there was insufficient data to confidently express a proposition, then questions were given instead. These programme theories and questions are based on the knowledge I had of my topic at the end of the scoping review and pilot survey, and as we will see in later chapters, go on to be refined and developed through the ethnographic fieldwork.

5.1 Knowledge of all kinds

This domain concerns the different definitions and understanding of what we mean when we talk about knowledge. This domain corresponds with the Purpose and Goals domain, as the reason for 'using' research, or other knowledge is linked to what can be said to be knowledge, and whether it is an output (such as a report) or an enacted process, whether it is explicit or tacit (or a combination). In their review, Davies et al (2015) begin by describing how the literature defines different kinds of knowledge and go on to develop the domain by inviting reflection on how what 'counts' as knowledge is also influential on

how it might be used. They explain that knowledge does not have a clear dominant definition, but that the models and frameworks within the literature they reviewed point towards what knowledge encompasses: tacit, experiential, empirical, individual, group, local and so on. The important point in the context of understanding the findings from the scoping review and pilot survey is a confirmation that knowledge is formed of more than research-based knowledge.

Findings from the scoping review and pilot survey

I translated this domain as being the ‘what’ of knowledge mobilisation: acknowledging and encompassing knowledge of all kinds (not just research-based knowledge) and other ways of knowing (which may or may not come from research outputs), and the way different knowledges are integrated.

From the pilot study interviews, there was a lack of agreement about what is meant by ‘research’: as either a product or as an activity. When thought of as a product, research-based knowledge was at times seen as being different from what they produced, preferring to call their work monitoring or evaluation.

Academic research-based knowledge was referred to as being at a different ‘level’ to what TSOs produce. Knowledge comes from many places, not just from academic research, but particular barriers were identified in relation to academic research-based knowledge: – a-contextual, lack of detail of the intervention, organisational preference for being collaborative in problem solving and decision making, rather than being purely driven to decision making by research-based evidence.

Other sources of knowledge, and kinds of knowledge which were used included: the knowledge and experience of staff and service users (reflections, gut feelings, client wishes and views); locally collected ‘data and information’;

knowledge of other organisations' work in the same area or with the client group; peers; conferences and networks and partnerships.

The scoping review and pilot study interviews indicated that there is a likelihood of diverging views on how research-based knowledge of what works compares with, relates to and is integrated with staff and service user knowledge of what works. The scoping review and pilot survey elicited a range of different kinds of knowledge that members of TSOs used in their work: peers knowledge, expert opinion, service user, staff; there was a whole host of different places from which knowledge could be sought or was available. Some of this was tacit, in the truest sense that it was hard to articulate ('gut feeling'), and some of this was more experiential, where the staff could refer to their own professional practice to 'evidence' taking a particular decision. What was striking was the frequency of references to the people who used their services, or those they were campaigning or advocating for and the knowledge that such people held of 'what works'.

Overall, the inclusion of so many other kinds of knowledge may mean that on its own, academic research-based knowledge is insufficient to guide action and decision making. Further, academic research-based knowledge was also seen as being at a different level to the members of the organisations I interviewed. What this different level was, or meant, was hard to articulate, potentially pointing to less explicit knowledge that had been acquired and understood but which was not yet articulated explicitly.

Domain 1 Knowledge of All Kinds
Initial programme theories and further questions

What different kinds of knowledge do TSOs use? Where does this knowledge come from? Why do TSOs seem to prefer to use client/user experience and knowledge?

If research-based knowledge does not take account of client/user tacit and experiential knowledge of what works then it is insufficient to guide action and decision making

How are different kinds of knowledge integrated?

5.2 Purposes and goals

This domain concerns the different motivations for and outcomes of research use, it considers the aim of the knowledge mobilisation activity and what it is intending to achieve. This domain mapped clearly onto my research focus so was not adapted. From a realist perspective, there would be an expectation that there would be variation in whether or not using research and other kinds of knowledge actually achieves these outcomes: depending on different mechanisms having different outcomes depending on different circumstances.

Davies et al (2015) discuss the different ways in which others have sought to conceptualise the different purposes and goals of knowledge mobilisation, and I have summarised these below.

- application of research findings to direct decision making (instrumental use)
- using research to persuade, inform and change minds
- tactical use of research to achieve a political end (this tends to use research as either a delaying tactic (e.g. "more research is needed before we can act") or to justify a position.

- problem-solving use of knowledge, where information from different sources are used to understand and resolve an issue (linked to hermeneutic use, where knowledge is used to explain and understand the social world)
- enlightenment/emancipatory or social purpose, where knowledge is used to understand and achieve social change or social justice

Findings from the scoping review and pilot survey

Purpose and goals of research-based knowledge use

The primary reason that TSOs gave for using research-based knowledge was related to funding. Either it was to secure future funding by demonstrating effectiveness (quoting research in funding/tender/grant applications), or it was a required activity of the funder to ensure further funding. Alongside this overarching aim were subsidiary outcomes such as increased confidence in the organisation's effectiveness (brought about by having conducted evaluation work of their services) which led to feeling more confident during funding negotiations. In the pilot survey and the scoping review using research-based knowledge was also thought to demonstrate to funders that the organisation understood their language, were intelligent and cared about quality, felt to be markers of an organisation that 'deserves' to be funded.

The motivations of people that work in TSOs to use research from the scoping review and literature appear to be dominated by an instrumental/direct use of research; the assumption being that creating and sharing research is proof of effectiveness and this is desirable.

This raises some points which need further exploration: do TSOs use research-based knowledge in other ways? Such as for its symbolic worth, tactically, and so on, and if so why is this? Furthermore, the assumption is that using research-based knowledge leads to funding, however, is this the case? Whilst it might be that commissioners do use research-based knowledge from TSOs in their decision making, in what circumstances does the research which a TSO provides have an effect? Why do TSOs think that using research-based knowledge in funding applications secures them funding? A lot of time, energy and money is needed to produce research, or to find appropriate research to back up what the TSO wants to do; is it worth them spending time doing this? What basis do they have for thinking this is the case?

Purpose and goals of other kinds of knowledge (not research-based).

What about other kinds of knowledge? What are the purposes and goals of using other kinds of knowledge? What other kinds of knowledge do TSOs use and why? The focus of the scoping review and pilot survey was on explicit, mainly research based knowledge, however, the findings from both studies also showed that people who work in TSOs use tacit and experiential knowledge too, whether learnt from peers, networks, through doing the job and so on. Why do they do this? How is this kind of knowledge integrated with explicit knowledge? The scoping review and pilot survey did not explore the purpose for using different kinds of knowledge in depth, although they did indicate that these are important sources of knowledge for 'what works', so what are the outcomes anticipated from the use of non-research-based knowledge?

**Domain 2 Purpose and goals of research use
Initial programme theories and further questions**

Instrumental use of research-based knowledge

If we cite research in our funding negotiations, then funders are more likely to give us money because they recognise we are an effective organisation.

If we cite research in our funding negotiations, then funders are more likely to give us money because using research raises the profile of our organisation and 'gets us on their radar'.

If we cite relationships/connections/partnerships with research producing organisations, such as Universities, then funders are more likely to give us money because these connections show we are research aware, and symbolically demonstrate the good things about our organisation – cost-effective, effective, and intelligent.

Further questions

What are the purposes or goals of using other kinds of knowledge?

What other purposes and goals do TSOs have for using knowledge (research based or otherwise)?

5.3 Connections and configurations

This domain is concerned with the ways in which different agencies connect and communicate with each other to mobilise knowledge. The definition of agencies given by Davies et al (2015) is broad and incorporates any organisation that has a particular remit to use or produce knowledge, or that facilitates the use of research. This domain relates to the processes that have been described to account for, and hopefully direct efforts to improve the flow of knowledge between producers and users. It encompasses the complex institutional, professional and social environments within which knowledge is created and shared. The review by Davies et al (2015) discusses Best and Holmes' three generations framework (introduced in Chapter 2): Linear models of research use and knowledge exchange where knowledge is 'packages' that

are disseminated to a rational and willing 'other' for them to interpret and implement. Relational models which consider learning as a situated and social activity, and knowledge as something that is co-produced between research users and producers within those spaces. Relational approaches are focussed on collaboration, building partnerships and capacity, and providing support for implementation and policy influence. Within these models, the emphasis is on ongoing mutually influential relationships. And systems models, which draw on the complex nature of the systems within which knowledge is created and shared, describing these systems as "conditional, contextual and relational." The difficulty with the systems way of thinking about how knowledge is produced and shared is that it is difficult to operationalise into tools or practical approaches for practice and implementation. The evidence base of evaluating this approach is weak because the model itself is complex, however the review does highlight three general principles which are important when thinking about systems approaches to knowledge mobilisation: polarisation (how far apart the potential users are from the producers), cost-sharing (how well the burden and cost of doing and sharing research is carried amongst those within a setting), and the informal and formal networks and social structures supporting the knowledge mobilisation.

Findings from the scoping review and pilot survey

I took this domain to relate to some of the facilitators for research use, as well as the processes of research use, and how the staff of the TSOs connected with others to discover knowledge for their practice. The findings from the scoping review indicated that facilitators to research use were developing relationships and connections between academia and TSOs for the specific

purpose of understanding the context that the TSO was working in and to use this to tailor and make the research more relevant and applicable. This relates in part to the relational model, whereby research users and producers develop relationships with the specific purpose of generating research which considers the different kinds of knowledge of different stakeholders.

However, despite this, the process of research use, (i.e. that there is such a thing) was not something readily understood by respondents in the pilot survey.

The pilot survey highlighted the much more eclectic, informal and un-organised ways in which members of TSOs went about finding knowledge for practice.

The kind of activities they talked about (talking to peers, attending conferences, reading reports) were much less active than the intentional processes outlined

in the three generations model. Which is not to say that the three generations model of relational or systems knowledge mobilisation does not apply, but

rather that *how* it applies with healthcare TSOs may be in terms of a less strategic, intentional yet still relational approach. Another aspect not discussed

in the three generations model but found in the pilot survey study was how members of TSOs saw connecting with Universities and other research

knowledge producers as being a way to raise the profile of their organisation

and to signify something important about who they are and what they do. In this

way, the purpose of the connection might not only be about getting relevant

knowledge for practice but also about the potential to build up the identity of the

organisation to impress and persuade commissioners (a key motivation for research use amongst TSOs).

The scoping review and pilot survey both highlighted the need for better

connections so that academic-produced research-based knowledge can

consider the specific local contexts which TSOs work in. In spite of the

recognition of the value and importance of developing these relationships, the pilot survey and scoping review showed that TSOs are not routinely engaged in or aware of such processes. So if it is important to connect with research producing organisations, why are TSOs not doing it more often?

**Domain 3 Connections and configurations in research use
Initial programme theories and further questions.**

If TSOs are more closely connected to academia, then research is used because it is more likely that their local context is understood and factored into the research which will make it more relevant and applicable.

If TSOs are connected with academia they think the likelihood of getting funding improves because it raises their profile as an 'evidence-based' organisation.

5.4 People, roles and positions

This domain is concerned with the distinct roles performed by agencies, and by individuals involved in knowledge mobilisation. The review by Davies et al (2015) suggested thinking about how those involved in knowledge mobilisation can be categorised as those who can act on the evidence, those who can influence those who can act, and those who can shape the context within which that action occurs; in this way it also relates to leadership, power and status in knowledge mobilisation activity.

The scoping review and pilot study identified processes of research use that are much more informal, eclectic and involving other kinds of knowledge rather than the intentional implementation of research-based knowledge. So this domain is translated into more than the specific people, roles and positions relating to an intentional process of research use within or between organisations, and

instead reflects the contexts of TSOs by referring also to those who have a more generic “role” around evidence within the organisation.

Findings from scoping review and pilot study interviews

The scoping review identified senior organisational support as an important facilitator of research-based knowledge use, as this clarifies the place and value of research-based knowledge within the organisation. Doing research was seen as a skilled, resource intensive activity, needing dedicated resources, and that if an organisation has a funded role/function on research then this increases research use. This might be because of how having one person to do the job means it is convenient, or that having a funded post demonstrates to all staff that research is acknowledged as a priority within the organisation.

In terms of understanding how research gets done and who does it in TSOs, in the analysis of the cognitive interviews, there were a range of responses which appeared related to the place of research within the organisation (who doing research ‘belongs’ to, whether it was a distinct role or everyone’s job). Views varied considerably on whether all staff did some kind of research (in terms of performance monitoring), to viewing doing research and using research-based knowledge as a designated role, carried out either within the organisation by a specific member of staff or team. If the organisation was affiliated with a National Charity, then research was viewed as a national responsibility, with important messages being communicated to local organisations.

What the scoping review and pilot survey also showed was that within this sample of organisations, research production was more readily understood than processes of research use. Research-based knowledge use was not necessarily recognised as a specific activity in itself: the view seemed more

than if there was relevant research, it was used. How this happened, and whether it was successful was not necessarily considered, and this forms the basis for the next section on Actions and Resources.

Domain 4 People, Roles and Positions
Initial programme theories

If there are strategic support and leadership for research use in terms of funding a specific role, then research is used because it is thought of as a priority.

If there is a funded role for research, then the organisation uses research, because there is someone convenient to do the research-related work.

5.5 Actions and resources

This domain is in relation to what needs to actually happen for knowledge to be mobilised – the actions and resources necessary to carry out knowledge mobilisation. The review found many models that provide a general overview of what actions are required and therefore what resources are needed. But whilst there are many models for how to mobilise knowledge, as these have not necessarily been tried out in practice and evaluated, it's not known how effective they are for planning knowledge mobilisation strategies. However, the review did summarise mechanisms thought to build research-based knowledge use: dissemination, interaction, social influence, facilitation and incentives and reinforcements. The extent to which these relate to other kinds of knowledge use and the extent to which they would be found in less formal approaches to knowledge mobilisation (i.e. the ones that tend to be used by TSOs) is not clear. What is clear however is that there is a wide range of possible actions that can

be taken to mobilise knowledge and that all of these have resource (time, skill, financial) implications. The description of this domain is concluded by drawing attention to the continued gap between what we know about processes of knowledge mobilisation and the translation of that knowledge into practical actions that do mobilise knowledge.

For my purposes, I used this section to explore the kinds of actions which TSOs *are taking* to use research and other knowledge in practice, in an effort to uncover the mechanisms which TSOs use to get research and other kinds of knowledge into practice. This section also includes a discussion of the findings that relate to the resources that TSOs have for research and research use, which leads back into the previous discussion of People, Roles and Positions.

Findings from scoping review and pilot study interviews

The findings from the scoping review and pilot survey that relate to this domain were grouped under processes of research use, barriers and facilitators to research use, strengths of TSOs in research use and resourcing research use. In relation to processes of research use, actions were related to the activities that members of TSOs did to find research (read websites, participate in networks, talk to peers, attend conferences), what they felt might be useful (skill development, third sector research repository, re-categorised research to make searching easier). However, the bulk of the findings from the scoping review and pilot survey within this domain related to the resources side of research use; not necessarily in the terms set out in the Davies et al (2015) review (resources needed to take the intentional actions to mobilise knowledge), but at a more fundamental level: organisations do not necessarily have resources to

put towards research, or the freedom to use their resources on research, or on using research based knowledge.

Conducting research or using research is not necessarily something that is resourced within the contracts that TSOs have with their funders. Some TSOs build in costs for core business activities when tendering for new contracts, to cover organisational functions necessary for the running of the project or service, such as payroll, or Human Resources. Research and research use are sometimes covered from core business; however, in the current climate of funding for TSOs, where they are being asked to strip back further as the value of contracts shrinks, using resources for research, or research use becomes harder in the face of needing to cut front line services, or even close them down. Using resources for research and research-use is not seen as essential, but rather as a luxury: so even if an organisation thinks that research is important, and using research is important, it may not necessarily be able to resource such activity. This is potentially a critical difference between TSOs and public sector NHS services insofar as TSOs have the discretion to choose not to have a research and development function, to not be research-knowledge based, and to forgo the benefits that might follow. The choice that they make in doing this is of course not free, being constrained by questions of priorities, justification, marketing and the broader funding climate.

Domain 5 Actions and Resources
Initial programme theory and further questions

How do TSOs get knowledge into action? To what extent do the following mechanisms apply to TSOs: dissemination, interaction, social influence, facilitation and incentives and reinforcements?

To what extent are TSOs free to use their resources for research and research use? How else is knowledge shared within the organisation?

If research is more accessible, then people that work in TSOs will use it because it is convenient to do so.

If people that work in TSOs learn research use skills, then they are more likely to use research because they know how to.

5.6 Context

The final aspect of the conceptual map is the role that context plays in knowledge mobilisation. The review highlights that context has been conceptualised in different ways, either as the setting within which a knowledge mobilisation activity or process is occurring, so in that sense, an inert, set context, or as an active ingredient, an interactive factor which has an influence on the success or otherwise in the knowledge mobilisation. Context was also defined in terms of the internal contexts within organisations, and the necessary conditions needed for an organisation to use research-based knowledge within itself, as well as the external contexts, in terms of political or social climate and the influence that has on what counts as knowledge and how it may be mobilised.

This is congruent with a realist understanding of the role that context plays: an interactive factor which influences knowledge mobilisation activities and processes; that is, context as an integral aspect of the knowledge mobilisation activity. In realist framing, context enables or constrains generative mechanisms of action, so in that sense, context is another active ingredient in understanding knowledge mobilisation in TSOs. Contexts can also be thought of as the

outcomes of other mechanisms working in different contexts, as well as contexts becoming mechanisms. In this sense then, each of the domains discussed so far can be viewed as contexts which enable or constrain knowledge mobilisation efforts. However, it is not necessary to do this: rather the focus needs to be on the contexts which seem to be most important to the mechanisms in question. So context is an important, integral factor in understanding how TSOs mobilise knowledge: therefore this aspect of the conceptual map has been interpreted as meaning the contexts within which TSOs operate, as well as the internal contexts of these organisations.

In earlier work, I explored how the different contexts of voluntary organisations impacted on their ability to provide effective services for women in the criminal justice system (Hardwick, 2013). In that study, I framed context following work by Pawson and Tilley, where they wrote of using 'context' as a way to think through the implications of 'what needs to be the case' at an Individual, Interpersonal, Institutional and Infrastructural level. For the individual level, that study, therefore, focussed on how the individual psychology, history, preferences, values and beliefs of those involved in either 'delivering' or 'receiving' the intervention impacted on the effectiveness of the intervention. At the interpersonal level, the focus was on the relationships between people as the context: how they related to each other, how they regarded one another. At an institutional level, I explored how organisational context influences and interacted with how they delivered services. Finally, at an infrastructural level, the concern was how that organisation worked in the wider criminal justice system and setting.

However, whilst this way of understanding and framing context seemed useful, I was not convinced it would capture the range of different contexts which might

be important in this work. Following an email to Ray Pawson, who was the auteur of scientific realism, the philosophical basis of this PhD, to invite his perspective on the question "what is context?", he made the point that the four aspects of context (Individual, Interpersonal, Institutional and Infrastructural) were an alliterative generalisation to get to the point that context is something which operates at different levels. Later in our correspondence, he wrote:

If one is trying to change individual behaviour you might find more profound contextual difference by looking at the inner of the four Is (rather than basic societal forms). If one is going for organisational change both wider institutional forces and recalcitrant individuals might make a difference. In general, by looking at similar programmes within a family, there are already many clues available in the literature about for whom and in what circumstances a programme might work. WE know a lot about context before YOU begin." (Pawson, R. 2016 personal correspondence)

This developed my understanding of context further because now I was sensitised to thinking about the "level" at which I was seeking to see change and to use that as a way to determine the important potential contexts which influence TSO knowledge use. As discussed in Chapter 2, an important context for TSOs is the context of austerity and how that is impacting on communities as well as a context of ongoing relationships, of varying degrees of contentment, between the state and the sector.

Findings from the scoping review and pilot study

Contexts which seem important from the scoping review and pilot study include funding (as both inner and outer context); the confidence of the organisation in its mission; the staff that work in an organisation; the clients that use their services.

The pilot study indicated that there were differences of opinion around whether or not changes to service delivery, motivated by research-based knowledge

were permitted by funders. I speculate that this might be to do with whether or not the member of the organisation felt their role as a TSO was to simply provide what they had been contracted to provide, regardless of whether or not it was effective or ineffective, or whether they felt that their organisation was autonomous, and could independently decide to go against delivering services as per the contract if they knew that there was a better, research-evidence-based way of doing it. Essentially, the extent to which the organisation felt that their funding would be at risk if they adapted the contract.

In turn, this perception of risk was based on how they interpreted their external funding context, or climate; which was in turn influenced by the organisations' sense of the place and value of knowledge for action in their organisation, as well as their understanding of their local commissioning context. In this way, the contexts which seemed likely to be most important were at a more macro level (austerity and its impact on the voluntary sector), and at an interpersonal level between the commissioner or funder and the representative of the organisation, as well as between those running services and those receiving them.

In terms of austerity and funding for TSOs that provide public sector services, the pilot survey shed light on how this influenced the extent to which organisations felt their role was to simply deliver what was asked (rather than risk losing the funding), or whether they wanted to influence the commissioner into commissioning what they knew was needed, based on their distinctive knowledge. In turn, this comes down to how confident the organisation is in their relationship with their commissioner, how well they are able to evidence the effectiveness of their way of working, and how content they are to sit with

the risk of a loss of funding. Competition is high amongst TSOs to win contracts, and so the risks of losing contracts by not delivering services to the letter of the contract are felt to be great, but only by some organisations. As not all organisations agreed with this position, it is potentially illuminating to consider what it is about the differences between TSOs that means some are more susceptible to avoiding risk than others.

Conclusion

In this chapter, I have used the conceptual map of domains of knowledge mobilisation to synthesise the findings from the pilot survey and the scoping review. This synthesis was then used as the basis for developing initial programme theories and further questions (see Table 4) which are explored further in the ethnographic case studies, Chapters 7-10.

Table 4 Initial Programme Theories & further questions on knowledge mobilisation in TSOs

| Domain | Programme theory/ further questions |
|---------------------------------------|--|
| Knowledge of all kinds | <p>What different kinds of knowledge do TSOs use? Where does this knowledge come from? Why do TSOs seem to prefer to use client/user experience and knowledge?</p> <p>If research-based knowledge does not take account of client/user tacit and experiential knowledge of what works then it is insufficient to guide action and decision making</p> |
| Purposes and goals | <p>If we cite research in our funding negotiations, then funders are more likely to give us money because they recognise we are an effective organisation.</p> <p>If we cite research in our funding negotiations, then funders are more likely to give us money because using research raises the profile of our organisation and 'gets us on their radar'.</p> <p>If we cite relationships/connections/partnerships with research producing organisations, such as Universities, then funders are more likely to give us money because these connections show we are research aware, and symbolically demonstrate the good things about our organisation – cost-effective, effective, and intelligent.</p> <p>What other purposes and goals do TSOs have for using knowledge (research based or otherwise)?</p> <p>What are the purposes or goals of using other kinds of knowledge?</p> |
| Connections and configurations | <p>If TSOs are more closely connected to academia, then research is used because it is more likely that their local context is understood and factored into the research which will make it more relevant and applicable.</p> <p>If TSOs are connected with academia they think the likelihood of getting funding improves because it raises their profile as an 'evidence-based' organisation.</p> |

| Domain | Programme Theory / further questions |
|------------------------------------|--|
| People, roles and positions | <p>If there are strategic support and leadership for research use in terms of funding a specific role, then research is used because it is thought of as a priority.</p> <p>If there is a funded role for research, then the organisation uses research, because there is someone convenient to do the research-related work.</p> |
| Actions and resources | <p>How do TSOs get different kinds of knowledge into action? How are different kinds of knowledge integrated?</p> <p>To what extent do the following mechanisms apply to TSOs: dissemination, interaction, social influence, facilitation and incentives and reinforcements?</p> <p>To what extent are TSOs free to use their resources for research and research use? How else is knowledge shared within the organisation?</p> <p>If research is more accessible, then people that work in TSOs will use it because it is convenient to do so.</p> <p>If people that work in TSOs learn research use skills, then they are more likely to use research because they know how to.</p> |
| Context | <p>External funding climate Interpersonal relationships Individual psychology, values, motivations and behaviours</p> |

Chapter 6 Methods for the case studies

The purpose of this chapter is to explain the methodology and methods used for the case studies. This chapter justifies why I used a case study approach and why I used ethnographic research methods (6.1), and how I selected and recruited cases (6.2). In 6.3 I describe how I accessed the field. The ethical considerations of the research are discussed in 6.4. 6.5 explains how I conducted the research, what data was collected and how, and the process of analysis is given in 6.6, followed by how the research was written up (6.7). The case studies are introduced in 6.8 and 6.9.

6.1 Case study approach and ethnographic research methods

In my research, I was not evaluating a specific knowledge mobilisation activity in healthcare TSOs. This was because in the scoping review and pilot survey I had not found many examples of intentional knowledge mobilisation processes to study and bearing in mind the concept of distinctive knowledge introduced in Chapter 2, I was also drawn to understanding the use of 'knowledge of all kinds' by TSOs which I did not think lent itself to looking at intentional knowledge or research use processes. I knew from my reading and conversations I was having with my supervisory team that an emerging thought was that knowledge mobilisation for the third sector is a relational or social process (Wilson et al., 2010) whose effectiveness is dependent on the individual, interpersonal and organisational contexts of those involved (Kothari and Armstrong, 2011).

Bearing these factors of the process in mind, it was clear that there would be a need for sustained immersion within a setting in order if I was to identify the pertinent mechanisms of research and knowledge mobilisation. I decided that the best way to approach this would be to do research that would let me spend

extended periods of time within a few TSOs to experience the ways that different kinds of knowledge were used and to learn and understand how and why this happens. I needed to uncover the nature of knowledge mobilisation in healthcare TSOs, and an ethnographic case study approach was suitable to achieve this.

Ethnography is the study of people, and cultures, in their natural settings, so as to give an account of how that culture or people do 'life'. It is based on the premise that to understand how and why particular social phenomena occur, it is necessary to observe the phenomena. Ethnography is a product (the monograph), a methodology (an approach to doing research consisting of extended periods of time 'in the field') and a set of methods (observation, interviews and documentary analysis). Ethnographic approaches, as demonstrated by others (Leslie et al., 2014, Swinglehurst et al., 2010), focus on developing an in-depth understanding of the cultural and contextual explanations of how and why phenomena happen. The rationale is that extended time within a setting gives an opportunity for understanding and explaining complex, culturally influenced processes.

Ethnographic research produces rich data which enables interpretation of the actions and meanings attached to actions, which practitioners, organisations or cultures engage in (Madden, 2010, Hammersley, 2007). The research outputs are detailed and contextualised accounts of the phenomena in question. In this way, it offers a useful approach to developing understanding in a relatively new research area where the cultures of the organisations are thought to have distinctive features. Furthermore, because knowledge mobilisation is not a single, discrete event, and may not be readily observable, the need for

immersion in the day to day work of an organisation, over an extended period of time, is preferable if trustworthy theories as to how research and knowledge mobilisation occurs are to be developed (Davies, 2008b).

Case study methodology has much in common with ethnography and is also used when there is a need to study phenomena in its own setting and on its own terms, and when the phenomena itself is not open to more experimental approaches. Case studies are appropriate to exploring phenomena when the researcher does not have control over events, and when the research questions require investigating a 'contemporary phenomenon within some real life context' (Yin, 2003). They are useful for generating theories as to why and how particular phenomena occur, and have been used in knowledge mobilisation research (Fournier, 2012, Stevens, 2011). Case study approaches, and ethnography are very much intertwined in their underlying philosophy: knowledge of a phenomenon is more readily found through observing it in its actual setting and as it happens (rather than 'artificially' as in an experimental setting).

For my PhD, I used the methods of ethnography to collect data, and identified the work I was doing with the case studies as 'ethnographic' in nature: i.e. focussed on observation of their routines and daily work, covering extended periods of time, using unstructured, opportunistic interviews, I developed my analysis, based on what I was seeing and within my overarching framework of the domains of knowledge mobilisation and my initial programme theories. I already had an idea of what data I would be looking for, and so was using the case studies as opportunities to develop the framework, to make further sense of the programme theories. Ethnographic research is initiated through the

identification of 'foreshadowed problems'; i.e. a sense of what phenomena is of interest and where it is likely to occur, and therefore what setting, society, culture or in my case, organisation to approach to do the fieldwork with. In my work, I used the programme theories developed from the first two studies to help me do this: they were my foreshadowed problems, and in the following section I show how I used them to select my case studies.

6.2 Choosing and recruiting the case study organisations.

I wanted organisations that were well established, so they had been trading or running services for more than 5 years. This was because I was interested in organisations that were providing services under contract from the NHS, and that had a track record of doing so, reasoning that this would make them more able to cope with having a researcher hang out with them for extended periods of time. I also wanted organisations that were based in Devon, Cornwall or Somerset, a practical consideration based on my location in Devon, and wanting to manage the associated costs of fieldwork (mileage, overnight accommodation). Finally, I was interested in mental health TSOs. This was because I had experience working for mental health organisations and reasoned that this would make it more straightforward to gain access and would mean that time would not be wasted trying to recruit organisations if I already understood (to some extent), their field of work. The other purpose in wanting an organisation with a mental health focus was that I wanted to explore how the mental health recovery movement influenced decisions about what works in mental health (and therefore what knowledge to use). The Recovery Movement places the person with lived experience at the centre of decisions about their

care and treatment and aims to empower them to be in charge, and to learn approaches to self-management to facilitate their recovery.

Once I had developed the programme theories using the KM domains from (Davies, 2015) I had a stronger framework to help guide case selection. I reasoned that if I wanted to understand more about how the initial programme theories bore themselves out in practice, then I would need cases that would give me the best chance of doing this. I took each of the Domains, and their initial programme theories and asked myself 'what would need to be the case if I am to explore this Domain, or these programme theories further with an organisation? What other characteristics might an organisation need to have to make them a worthwhile case study?' Some of the characteristics counted for more than one domain, so rather than repeat them, I've grouped them together.

Purpose and Goals

For the Purposes and Goals domain, it seemed quite obvious that I would need organisations that are funded in a significant way by the public sector. If part of how TSOs use research is related to how using it influences how they are seen by others, particularly funders, then it would be important to work with organisations that have a commissioning/contracting relationship with commissioning organisations, – i.e. my case would need to receive money from NHS or other public sector organisations to run services: either on behalf of the public sector or alongside them. Guided too by Maxwell (2012) and others (Hammersley, 2014), I was also pragmatic, and therefore wanted organisations that would be interested in working with a researcher, rather than wasting time trying to convince an organisation to join in. One way that an organisation might show this is if they were interested in promoting their organisation, keen

on showing that what they do works, want to or have worked with research institutions and who are in a commissioning relationship with the public sector. Ideally, they would have a funding or business manager, and potentially a dedicated role for research and development, which could signify that they were already research-aware and might be interested in learning about why their organisation uses knowledge.

Knowledge of all kinds/ Connections and configurations

The programme theories showed that I would need to select cases that show awareness of the importance of service user and staff knowledge in their work. So that I could observe the use of explicit knowledge, I would also need cases that were aware of and actually used research and knowledge in practice and decision making. I decided that I would know this through reading their website and seeing if there was evidence that the organisation subscribed to, or was involved in Recovery Based practice, whether it implemented evidence-based interventions, or had previously been in a partnership with other evidence-based/ aware organisations such as NHS organisations, Universities, 'think tanks'; or if it had run its own evaluations. I felt that observation of tacit knowledge mobilisation would be something difficult to discern from outside the organisation, and at the time of selecting cases, I was inexperienced in determining markers for this kind of process. To accommodate this uncertainty, I made a pragmatic decision that necessarily all organisations mobilise tacit knowledge, the "know-how" of how to do their work, so it was not essential to come up with a marker that would support case selection. Potentially, working with a service-user led organisation might lead to more 'tacit knowledge

'mobilisation' organisation, but these were unlikely to also be running the kind of larger scale contracts from the NHS that I was interested in understanding.

People, roles and positions

The programme theories talked about the importance of leadership in knowledge mobilisation, and how having a role for research, or research use was important in facilitating knowledge mobilisation. Therefore, it seems obvious to state, but the organisation needs to have a formal structure so that there are leaders, and decision makers, and a senior management team or structure, and potentially a member of staff or team identified as having a responsibility for research, research use or evidence use.

Actions and resources/ Contextual factors

In this domain, the programme theories were focussed on resources for research, and the actions that might or might not flow from that, depending on how the organisation is sensitive to its external context and relationships with its commissioner. So it would be important to do the fieldwork with organisations that had resources and again had relationships with commissioners, and who were aware of the wider policy context within which they were operating.

And finally, to find out whether or not an organisation has these different characteristics, I decided to look for information online in the first instance, then talk to colleagues about the organisations which they knew of, and to think through the contacts with organisations that I had already developed during the fieldwork. All these points are summarised in Table 5 below.

Table 5 Characteristics of Case Study Organisations for case selection

| Domain | Characteristics |
|--|--|
| Purpose and goals | Public sector funded In a commissioning relationship Orgs interested in promoting themselves through using research Potentially have or have had working relationships with research producers Ideally, have a funding/ business manager and potentially a dedicated role for research |
| Knowledge of all kinds/ Connections and Configurations | Aware of the importance of service user and staff knowledge Recovery based organisation |
| People, roles and positions | Formal organisational structure Leadership Potentially dedicated role for research |
| Actions and resources/ Contextual factors | Well-resourced organisation (i.e. not on the brink of financial meltdown) Work with commissioners Aware of wider policy context for the third sector and the NHS |

6.3 Accessing the field

I had intended to identify potential cases and approach them during the survey phase of the PhD. However, as the survey did not go ahead, I used the work I had already done on developing a database of TSOs and drew up a shortlist of organisations who were eligible, based on the list of characteristics I had developed. I approached these via email initially, to introduce myself and tell them about the project, and invite them to participate. This was cold calling, and unsurprisingly, I was not inundated with replies, and it was actually through a conversation about my research with a colleague who was a Trustee at Chapter One Wellbeing that I thought I'd found my first case study. The organisation met the criteria I had developed, and my colleague encouraged me to approach their Chief Executive directly, which led to a meeting with their Operations Director for health and social care services and in the end, their recruitment as a case study organisation for me to work with.

Finding my second case study was a bit more problematic. Having had no success from the cold calling, I approached one of the senior directors who I knew through a work colleague from a previous job. He worked for an ex-NHS service that had become a social enterprise. We met, and he sounded interested and put me in touch with two colleagues who managed the organisations Research and Development work. I met with one, who said that the other one was the 'real' gatekeeper and so I pursued meeting with that person. I had already started fieldwork with Chapter One Wellbeing and was half way through when despite my efforts to meet with this person, I had still not had so much as a conversation! I decided it was time to change tack and approach another organisation.

I contacted one of the organisations who had given a lot of useful data in their pilot survey interview and who had wanted to keep in touch with my research to see if they would be interested. I knew they met my case selection criteria, and they also used to be part of the NHS, as part of the community rehabilitation services which mental health care trusts used to provide (vocational training); but they had been an independent social enterprise for many years now. They were keen to meet, so I met with their Board to introduce the project and myself, and they immediately accepted the opportunity.

6.4 Ethics

6.4.1 Organisational and staff consent, confidentiality and anonymity

When I had the initial contact meetings with the two organisation that went on to be my case studies, an important part of the conversation was the ethical implications of the research, and how consent would be given. I purposefully targeted the senior management level, rather than going in at a service manager level, because the aim was to get agreement and sign off for the whole organisation. I also needed to know who it was in the organisation that was in a position to do that. I devised a consent form and information sheet (Appendix 6) that would allow the Chief Executive or Chair of the Board of Trustees to agree to let me do my research with them on behalf of the organisation. I had thought that this was going to be a very difficult part of the process: that some Board members or senior staff would put up barriers to me doing the work with them, so I was surprised that this actually proved to be a very straightforward process: in both organisations, being approached by a researcher wanting to work with them in this way (observation, sustained period of time) was something they were very keen to facilitate. I agreed with both

cases to do their staff induction, specifically to be trained in their data and information security policies, and that I would get a Disclosure and Barring Service (DBS) check to work with vulnerable adults.

However, getting organisational permission to do the research was only one step: at a team or individual level, I also needed permission to be there, and to observe. At times, when I met new staff, I was met with blank looks or suspicion, as staff were not entirely sure what I was there to do or convinced about the relevance of my work to theirs, or wary of whether I might be working for the management in some way and going to 'tell' on them.

I had anticipated a lukewarm reception from some staff: the irrelevance of academic work to the day to day work of third sector organisation staff was something which had come out during the pilot interviews, and so I dealt with this indifference or hostility in three ways: being authentic (shown through body language and increasing the amount I listened, rather than spoke), reassuring them that my work was confidential, and emphasising how what I was doing was relevant to their work.

Every time I went to a meeting, or a service, I reminded staff and service users of who I was and why I was there and explained that if they did not want me present, they could ask me to leave directly, or ask someone else to ask me to leave. This happened on a few occasions, or I sensed that the conversation which I'd stumbled in to (by walking into a shared office space), was private and so I excused myself. At times, I felt awkward doing this, but I also knew it was part of gaining and retaining the trust of those I was working with that I would not impose myself too much.

During my time with Chapter One Wellbeing, I offered to do a short qualitative service evaluation for the Recovery Learning College. In that instance, I was interviewing volunteers, who also had experience of mental health distress, and so I used consent forms with them, and an information sheet, (Appendix 7) as I explained the purpose of the interview and how the data would be used. When I interviewed paid staff in either organisation, I used the same interview information sheet and consent form, which were sent to the participant in advance of the meeting and read with them before the interview commenced. I explained how they could choose not to answer the questions I asked, or to terminate or suspend the interview if they wanted, or if they wanted me to omit detail from the transcript after the interview.

The Third Sector is well networked, and ensuring total organisational anonymity was not something I was able to offer. The write up of the fieldwork could identify specific features of the case studies which were unique to them (places, type of service offered, ethos), and this was made clear at all stages of the research process: from initial conversations to the day to day observation work I did. The senior leaders in both organisations seemed unconcerned by this; I sensed they felt they had 'nothing to hide', and they were more interested in using what I would do to help them learn rather than being overly concerned about their organisation being identified. Nevertheless, in my write up, I anonymised places, names and other identifying features to protect as far as I was able, their identity.

6.4.2 Cause / potential cause of harm or stress

One of the important aspects of ethical conduct in research is to ensure that the research work and the researcher does not cause unwarranted harm or distress

to the people or places under study. As my research was focussed on understanding processes of knowledge mobilisation in third sector organisations, I was not seeking personal information about the people I was observing (such as their mental health history, diagnoses, medication and so on). However, part of the culture of both organisations was including and involving people with lived experience of mental distress in providing their services (either as peer trainers, as volunteers, or employed as staff); because of this, I agreed what the process would be for me to follow should someone become distressed or share sensitive or important information (about their wellbeing) with me: I would invite them to talk to a colleague or a manager about it in the first instance, but if they were reluctant to do this, or their level of distress warranted it, then I would speak to a designated person in each organisation about them, on their behalf. I would also let the person know that I was doing this, and why I was doing it. Once I had gained a degree of trust with those working within the organisation I was treated more as "one of the team" but I was clear and reminded others on occasion, that actually I was not a paid member of staff or a volunteer, but a researcher, and as such if they were experiencing difficulty it was my duty of care to pass that on to someone that was responsible for the welfare of the staff.

6.5 Data Collection

6.5.1 Observation

I used participant and non-participant observation, so I took my laptop and books to their workplace, and sat in one of the offices, and worked, whilst participating in the life of the organisation (talking to people, having lunch together, going for drinks after work). I also attended specific meetings, and

training courses, as well as organisational development or team away days. During the day, I would write brief notes on particular things I'd seen, or things people had said, or instances that resonated with my sensitising questions and overall purpose, as well as instances that related to broader concepts like organisational culture. At the end of the day, I would either write up these jottings into field notes or make an audio recording, which I wrote up into field notes later. I used an App called Evernote³ to record the jottings and field notes and audio. Evernote can be used on a phone, tablet or laptop, data is secure and saved in the "cloud" and is user friendly. I wrote my field notes up as diary entries of what had happened that day, what I'd witnessed, phrases people had used, or particular words that had struck me and resonated. I also noted down ideas, contradictions, puzzles and other thoughts about the work in a separate folder of the App.

I conducted 270 hours of fieldwork with the first case study, over a 20-week period, and 190 hours of observation with the second case study, over a 15-week period. The difference in time spent with each case study was due to annual leave, attending conferences, and sickness, alongside the pressure to finish fieldwork so that writing and analysis could begin proper.

6.5.2 Interviews

During the fieldwork, I spoke to many people, and these conversations informed the direction and focus of my research. In these situations, where we might be standing in the kitchen talking whilst the kettle boiled, for instance, it was not conducive to the conversation to ask the person for their written consent.

³ Evernote Corporation (2018) Evernote (version number 6.14.5.7671) [mobile application software]. Retrieved from <https://evernote.com/>

Instead, if there was something which they said which sparked my curiosity in relation to my work, I invited them to an interview. Prior to those interviews, I sent the individual an information sheet and consent form (Appendix 7) and talked them through this before the interview took place. In this way, I conducted interviews with selected key informants, chosen because of what they had said or done earlier in the fieldwork. I carried out the interviews at the office spaces of the organisations. In my first case study, I offered to conduct a short qualitative evaluation of the work of one service, and these interviews also provided more data for my broader analysis. By the end of the fieldwork, I had interviewed a range of staff and volunteers, some twice, about their work, what they did and how they used knowledge (see Table 6).

Table 6 Interview participants

| Chapter One Wellbeing | Carnarveon |
|--|-------------------|
| Project worker 0 | Project worker 2 |
| Volunteer 7 | Volunteer 0 |
| Project Manager Chloe (twice), Louise (twice), one other project manager | Project Manager 2 |
| Senior Manager Anthony (twice) | Senior Manager 1 |

6.5.3 Documentary analysis

I collected the following kinds of documents from both case studies: minutes of meetings, newsletters, information on organisational workshops and away days and organisational policies, procedures and other documents concerning the delivery of services, organisational quality and adherence to national policies. At the first case study, I had an email account, but there were difficulties with accessing it remotely, and after a few weeks, it became clear that having it was

not necessarily vital to the development of the fieldwork there. Participants contacted me using my University email address, which was more reliable. I was included in the papers of meetings, and as the organisation was going through a process of organisational development, the papers from those communication day meetings were also sent to me. I also took photos of flip charts and other documentation for my records. At the second case study, however, the remote access to email did work, and so I was privy to conversations such as staff members asking everyone for knowledge of particular services, support or other advice and so on.

6.6 Data Analysis

Data analysis and data collection occur concurrently in ethnography (Madden, 2010, Hammersley, 2007), as the activity of writing up field notes following observation or interviewing is also the process of sense-making and interpretation. So the processes of data collection, analysis and writing were iterative. The approach that I used in data analysis is akin to what Maxwell calls categorising and connecting "moves" in an analysis (Maxwell, 2012) where the researcher moves between data and theory, and back to develop coherence. I had in mind the Domains of knowledge mobilisation and the initial programme theories, but I was also open to what was happening in front of me in the field work: I used the previous work to sensitise me to the kinds of situations and phenomena that were important to study, rather than to direct me to the "only" aspects of the organisation that I could be interested in.

During the field work, I spent time writing and thinking about what was occurring in the case studies. As I wrote up field notes, and re-read them, I developed ideas of potentially important experiences or observations, and I made note of

what these were and how they might be relevant. Approximately half way through the field work with each case, I took a week away from the field to consolidate what I had found and to re-focus the data collection. I did this by summarising the field notes onto a white board and looking at the different ways which I might go about organising the writing.

After the field work stage had finished, I re-read the field notes, listened to the audio recordings, or re-read transcripts and also read the documents I had gathered. Following this sensitisation, I inductively developed codes, and then using those, as well as the programme theories developed previously, I did a 'rough and ready' coding process to catalogue and categorise the data and highlight which domains it might be pertinent to and what additional areas of knowledge use by TSOs were emerging as important.

Each of the programme theories also offered a route through the data, and so to determine which ones to focus on I prioritised the programme theories through considering three aspects: 1) how relevant they were to existing debates in knowledge mobilisation research and third sector research. I defined relevance with reference to the 'gaps' in knowledge identified in the literature, discovered through my scoping review and reading the broader; 2) how the programme theories extended current debates in third sector research and knowledge use identified in Chapter 2; and 3) how the programme theories answered my original research questions.

Having done this, three main areas where knowledge was underdeveloped were identified, with their relevant domain of knowledge mobilisation (and therefore programme theory) in brackets:

- How the culture of TSOs impacts on knowledge use. (Actions and Resources)
- Understanding how the knowledge from staff and service users is integrated with other kinds of knowledge (e.g. research-based knowledge) (Knowledge of all Kinds)
- The reasons for using knowledge (Purpose and Goals)

Having prioritised the programme theories to explore further, I then re-read the field notes, listened to the interviews and read the documentary evidence and began writing and analysing how these programme theories had played out in the case studies. In this way, my approach to analysis was deductive, seeking to explore how the programme theories were represented in and refined by the fieldwork.

6.6.1 Using subtle realism in the ethnography

I handled the data I collected as being constructed accounts of a mind-independent reality. This was based on Hammersley's concept of "subtle realism" (Hammersley, 2007), and how in ethnography, the purpose is to produce faithful reproductions of the stories from the field, whilst also recognising that in doing so, you are also constructing another version of reality, of what really happened. The decisions on what to put in and leave out, the way that language is used, the focus of the field work as well as the writing are all part of constructing an account of what occurred. Hammersley stated that it was not possible for ethnographers to give a fully objective account, as the act of ethnography is always one of subjectivity, the ethnographer looks to build a story and in that construction, they are creating anew what happened. He

suggested then, that instead of ethnography proposing that it is able to give an unfiltered account, of 'as it happened' reportage, ethnographers acknowledge that their writing is one amongst many different ways of understanding the same phenomenon. Where his thinking is realist is in the sense that he, like me, thinks there is a mind independent reality which exists, and that the constructions that ethnographers create are mimics of that, they are not new or alternative realities, but echoes of the reality seen through a glass, darkly.

6.7 Writing out and writing up

Initially, I wanted to have long descriptive chapters of each case study, followed by chapters that focused on their knowledge use processes. So I duly wrote up a chapter on my fieldwork with the first case study, Chapter One Wellbeing.

The voice that I used in that write up is what John Van Maanen would call a "confessional tale" (Van Maanen, 1988), that is, it places the researcher centre stage, focusing on how what occurred happened to them, and what it meant to them. I knew it was not perfect, but I felt it covered the ground in terms of describing the organisation with enough depth to make the following chapters on knowledge use understandable. The feedback on this writing from my supervisory team soon disabused me of any notion that this was the right way to proceed with writing up: their feedback indicated that it was self-indulgent and almost gauche, with little critical analysis or explanation.

I took the news quite hard, and literally went back to the drawing board of my ethnographic text books to try and understand what had gone so wrong and what else I could do. I felt at this time very strongly the difficulty of wanting to authentically use ethnography as a methodology within a discipline (medical studies) that takes a much more pragmatic approach. There are many

examples of ethnography within health services research, but these are often 'focussed' ethnography or ethnography which takes what I felt was a potentially exploitative 'using' approach: the setting was there to be used for the purposes of the research, with the researcher setting the pace, content, focus and so on, rather than a more classical approach which was akin to getting the seat of ones pants dirty in hanging out within a setting, seeing what occurs and making sense of it in a much more inductive way. I had always been committed to following the classical route but had made the mistake of then thinking that meant the writing had to be all about me.

So I read some more qualitative research methods books (Wolcott, 1994 {Hammersley, 2007 #75, Van Maanen, 1988}) , and emailed Jon Van Maanen to get his take on where I had "gone wrong". What I learnt was that *before one can rock the boat, one has to be in it*. In fact, he went as far to say that I should do whatever was necessary to get through the gate of my PhD, and one way to do this would be to use a 'realist tale'. Realist writing in ethnography is akin to scientific realism, insofar as it attempts to locate the writing in the 'real world'; so taking out asides, personal impressions and as far as is possible, the author's voice, and its focus is on using the power of the narrative to demonstrate that you, the observer were 'there'.

Suitably girded with this wisdom for action, I started writing out the findings again. I wrote out each domain as a chapter in itself: logically, it would make sense for a chapter to address each of the clusters of programme theory. However, this proved to be challenging in a different way: it is difficult to write about different kinds of knowledge without writing about how that knowledge is used, and for what purpose. The examples from my fieldwork were not isolated

to instances of "simply" describing the kind of knowledge used, they also involved how it was used and why. I felt I was trying to make the data fit my framework, rather than really listening to what the data had said. The Domains had proved useful throughout the research as an anchor point, around which the design and data collection had flowed, but when it came to writing up, the data was clipped and taken out of context, or was at risk of tedious repetition, as I would need to use the same examples in three chapters to cover the ground of 'what knowledge is used, how and why'. This was not working for me, the point of doing ethnographic work was to understand the social phenomena of knowledge use in its setting and context, and on its own terms, and I certainly was not producing that kind of account.

I decided that the writing would be more elegant and easier to follow if I were to roughly theme the different kinds of knowledge that TSOs use (tacit and explicit) as the overarching categories, and to then cover the domains of why and how knowledge was used within each chapter, using examples to illustrate this. I re-charted the fieldwork and interview data along these lines, and it made the writing clearer for me, and the findings were now properly contextualized. It also meant that by the time I came to be writing these chapters, I was very familiar with my data, having worked it over in different ways and for a considerable length of time.

A realist approach to reflexivity.

Reflexivity is the practice in qualitative research of considering your own position in the research and how your experience and knowledge influence what you are doing when you do research. To be reflexive is to regularly spend time thinking about the perspective and biases you may have towards your work or subject, to consider how this might be influencing what you are doing and why when in the field, and how it may impact on what you write. It is not about preventing bias, but about openly acknowledging the subjectivity of the work. From a realist and from a qualitative perspective, there is no objective stand point from which to conduct research: all research chooses a lens to look through, whether this is acknowledged explicitly or not; there is no omnipotent viewpoint from which 'objective' knowledge can be obtained. In qualitative research subjectivity is not treated as a problem to be dealt with, but rather a regularity of these approaches and methods, useful to enable in depth field work and insight into the phenomena of interest. Reflexivity is the process and practice of making more explicit these subjectivities so that the reader can judge and make their own decisions about the work which was done and its worth and value. In "What's wrong with Ethnography?", Martyn Hammersley talks of how qualitative research quality should be judged and seeing as there are few hard and fast rules about doing qualitative research (he talks more in terms of preferences), then it is through the interaction between the reader and the text that a judgement is reached about the quality of the work.

From a realist perspective, the researcher's attitudes, beliefs and attendant behaviours are real, in the sense that they also have causal powers to influence the research process. My history and background working in the voluntary sector did influence what I did when I was working with my case studies, from the ease with which I adapted the language I used to those I was with, to how I understood how to conduct myself in the different situations I found myself in. For me then, much of this would be second nature, and so I knew I needed to be active in reflecting on how my own experience and actions influenced the research process, and in particular, may have blinded me to important phenomena.

In the prelude, I explained that I come from a voluntary sector background, that I have been a Trustee and have worked for voluntary organisations. This had several implications for the fieldwork: I needed to make what felt familiar to me (mental health third sector organisations) feel strange again so that I would not "miss" valuable social phenomena that for an outsider would seem notable. In addition, my experience meant that I needed to be aware of my desire to potentially be biased in what I saw; essentially, that I would be "rooting for" the case studies and would find it difficult to be critical or negative about what they were doing. However, Hammersley influenced my thinking and work here, saying that the purpose of ethnography is not to evaluate or judge whether what is happening is right or wrong, good or bad, but rather to understand it and explain it. In this way, I adopted a more neutral standpoint towards my cases; interested in understanding what they were doing and why, rather than judging (positively or negatively) and why. How this bore out in practice influenced the work in several ways: I could be honest with those

that I met, that I was not there to judge or "tell" on the organisations I spent time with and that my interest really was in what they were doing and why.

This was a great foil to those I met who were suspicious or overly enthusiastic about what I was doing: it tempered their expectations and invited their honest responses to my questions and probing.

On a personal level, I was keen too that my work described the experience of spending time with these organisations as clearly as possible; in conversations I had with colleagues at the University before I started the fieldwork, when I started to talk about TSOs and research use, I heard folk-tales about charities they knew of who did terrible, un-evidence based things, that they were clearly run by amateurs who wouldn't know a systematic review if it bit them. I knew from my experience working in the sector (as well as the pilot survey), that there was some truth to that (in terms of knowledge of research methods and how to access, appraise, adapt and apply research-based knowledge), but I also knew that it was a patronising and naïve view to take: that somehow charities were unsophisticated in their use of knowledge. I wanted to explore some of these assumptions.

On the other hand, the temptation to then turn the fieldwork into a crusade against intellectualism would also not serve the work, or the organisations well. The aim instead was to simply go and see what kind of knowledge organisations were using, and how and why; and to write about that as honestly as I could.

I had gone into the fieldwork with a series of thought out ideas (the programme theories and attendant questions) and a sense of what it was that

I was to achieve whilst with the case study organisations. Therefore I knew I was not going to be in a position to be as inductive as an ethnographic approach might aspire to be, seeking to develop theory from the ground up. However, as a fledgling ethnographer, I was keen to practice understanding the meaning or explanations which those in my field work attributed to their actions, rather than simply transpose what they did into the programme theories. Observations that I carried out were followed up with questions to elicit the meanings which people attributed to them, and in this way, I cultivated a balance between my pre-supposed theories of how knowledge mobilisation occurs in third sector healthcare organisations, and how those who are doing this understand what is happening.

From a realist perspective, there is a tension here again: relying on what people "think" about what they do can lead to further conjecture and discussion, but may not necessarily translate into what they actually *do* do in the real world. Therefore a balance needed to also be struck between what people said they do and why, and what they actually did and how that fitted with my programme theory refining.

I knew that looking for contradictions to my programme theories, such as unanticipated outcomes or differences in terms of how knowledge is mobilised, would help me understand and refine my programme theories, but that I would need to be open to this, and to practice reflexivity to prevent myself from only seeing what I wanted to see.

I did this by mentally bracketing the programme theories: they were there for me to reflect on at the end of the day, but whilst I was physically "in" the

setting, I cultivated an openness and awareness to what was actually happening and why, following my gut feeling about places or people that it would be fruitful to talk to, but not being bound into only being interested in my research questions. I also wrote up in my fieldnotes about how I was finding the research process, what I was learning, and thought about my own prejudices and perspectives and how these were influencing what I was doing.

In the Chapters on the fieldwork that follow (Ch7-9), I include short summaries of this reflexive work, similar to this box, to provide an account for how my perspective and experience influenced the research process and data collection and analysis.

6.8 Introducing the case studies – Chapter One Wellbeing

Chapter One Wellbeing was a newly formed charity, created by a merger of two other charities (Change and Connections Trust (CCT), and Grace Foundation). The process of the merger had started before the fieldwork took place and was ongoing throughout the fieldwork. CCT provided mental health support services (clinical and non-clinical) and Grace provided employment support services to people who might be long term unemployed, or with long term conditions, veterans, and people in the criminal justice system. Chapter One Wellbeing is a Company Limited by Guarantee and as such has a Board of Trustees, who are also Company Directors, and are responsible for the governance of the organisation, the production of annual reports, ensuring annual returns to Companies House and the Charity Commission and ensuring the organisation

fulfils its obligations and mission, as set out in its governing document, known as the Memorandum and Articles of Association. The Board set the strategic direction of the organisation but in common with many small and medium size charities, they delegate their authority to the Chief Executive. In turn, the Chief Executive works with a small group of Directors (the Executive Team) to enact the will of the Board, and to gather and provide information and intelligence to the Board to support its decision making. Below the Executive Team Directors are the Service and Team managers, and their Deputies, and then the front-line workers and volunteers.

The mental health services are spread out across two Clinical Commissioning Group areas but mostly clustered around a large conurbation on the coast. CCT was established in 1989 to provide residential mental health services, following the closure of two large mental health hospitals in the county. Since then, the range of services increased and during the fieldwork CCT provided an independent hospital (Larchmont), two residential care homes (The Granary and St Mary's), three houses for supported living (Hill House, Maybury Court, Marchmont Rise), a recovery learning college centre called Phoenix, and a service for people with autism (which included community and building based services). They have an annual turnover of around £2m, and employ approximately 140 staff, with the nursing staff on NHS Agenda for Change terms and conditions (pay scales, pension arrangements). The funding for the services they provide comes mainly from the local Clinical Commissioning Group.

People

Sara – Chief Executive

Sara used to be the Chief Executive of CCT and took over the position of Chief Executive of Chapter One Wellbeing during the merger process. She worked for a large NHS mental health trust in London as a ward manager, and when she started working at CCT it was to manage and run Larchmont. She was approachable, knowledgeable and direct.

Anthony – Director of Health and Social Care

Anthony was the Director for the Health and Social Care services, a relatively newly created post due to the merging of CCT and Grace, and a member of the Executive Team. He had a long history of working in third sector organisations, most recently for a large housing association. He had oversight and responsibility for all of the health and social care services, and he liaised with local healthcare commissioners on behalf of the organisations. He was astute, trustworthy and diplomatic.

Chloe – Business and Innovation Manager

Chloe had worked for Grace prior to the merger as their training manager, and since the merger, she was working as the Business and Innovation manager. Her role encompassed a range of responsibilities and activities, including impact evaluation, grant and tender writing and organisational development. She was quick but thoughtful, experienced and diligent.

Louise – Phoenix Learning Community

Louise trained as a general nurse and went on to complete her mental health nursing as part of her career development. She had worked for CCT for over 15 years before the merger, in management and support roles at Larchmont and the Granary. She was clear that her role at Phoenix was not as 'the

manager', but rather as someone who was there to facilitate people with living experience of mental health issues to run the service. One of her favourite quotes was 'if the lunatics take over the asylum, there is no asylum', and she very much saw her role as being to facilitate that happening.

Nina – Clinical Governance Manager

Nina was also a nurse and like Louise started as a general nurse and went on to complete her mental health nursing. She, like Louise, had also worked and managed other services in CCT.

Tilly – Peer trainer

Tilly used to work at the local further education college as a lecturer, but following a mental health breakdown, had to leave. She had attended courses at Phoenix to learn how to manage her mental health better and had gone on to complete the peer trainer induction and was now one of Phoenix's longest serving peer trainers.

Ben – Peer trainer

Ben was a musician living in London before a tragic event caused him to move out of the city. This event became the trauma from which he developed Post-Traumatic Stress Disorder, and he started coming to recovery courses at Phoenix and like Tilly then became a peer trainer.

Meetings

During the fieldwork different meetings were observed: the Organisational Development Group (responsible for managing the merger process, focussed on developing a coherent and corporate organisational identity, mission and values), the referral and governance meetings (where the management of the health and social care services was discussed), the Health and Social Care

Team meeting (which focussed on broader organisational performance and management issues).

Places

Chapter One Wellbeing provides a range of services in different houses and buildings for people experiencing mental distress; The Granary (for people in acute mental distress, also known as a crisis house), Hill House, Maybury Court, Marchmont Rise (all longer-term accommodation) Larchmont (a hospital) and Phoenix (the recovery learning community). I only visited Hill House once during the fieldwork and did not visit Maybury Court or Marchmont rise as these were essentially people's homes rather than the location of services.

The Granary

The Granary is a crisis house, a place of refuge for people experiencing mental health distress at such a level that they need some time away from their day to day life as an alternative to, or to prevent a hospital admission. The Granary is a large old house, overlooking the sea, with a garden. There are 7 bedrooms, individually decorated with en-suite, and a communal sitting room, kitchen and separate dining room. People normally stay between 3-10 days, and during their stay, they are given the tools needed to develop strategies for self-management to enhance their recovery. Support is person-centred and aims to build self-confidence and resilience to better enable residents to manage their mental health more proactively. Referrals for the service come from the Crisis Resolution and Home Treatment Team, and the staff act as care coordinators, pulling together the range of services and supports for individuals. Organising medication was an important part of this role, according to the staff, who complained about how difficult it was to get a script for people before they left the crisis house. This focus on medication was not because they wanted to be

pseudo-clinical, the staff were clear that "We don't treat people, we support them. We are not interested in their diagnosis, but in what they present when they arrive."

Larchmont

Larchmont is an independent hospital, owned and run by Chapter One Wellbeing in a residential building on one of the main routes into one of the small seaside towns of their patch and in common with the other services provided, it has no signage to mark it as a psychiatric service. It is a mixed sex hospital, and there are 12 bedrooms. The kind of care provided is referred to as either step-down (for people leaving hospital), or crisis, to avoid an admission to the main NHS psychiatric ward at the local general hospital. Qualified RMNs and support workers make up the staff team, with the manager of the service and her deputy were nurses who did some of their student training at Larchmont and when they qualified returned to work there full time. At the time of the fieldwork, Chapter One Wellbeing was in the process of purchasing a new £1mill building for the hospital services.

Phoenix Learning Community

The Phoenix Learning Community was housed in an old two storey house on the main street in the same town as Larchmont, about 2 minutes' walk away. Once again, there was little signage marking it as a mental health centre, except for a fading sign in one of the windows. The building looked like it may have been a staging post pub; when facing the building from the front, there are two bay windows on the right, and on the left, a mezzanine floor, and two large wooden doors, painted black, where you might expect a coach and four to fit. Through the two large wooden doors is a small car park and a garden with an undercover area for smoking. The main door (which is at the side of the

building, under the mezzanine floor) takes you into a short corridor, with a large room on the right (the training room), and a dining room with a large table covered with an oil cloth and kitchen on the left. The walls are covered in motivational posters, and leaflets and all kinds of positive messages about mental health, wellbeing and recovery.



Figure 4 Phoenix

Phoenix has people with lived experience of mental distress as peer trainer volunteers, using their skills and knowledge of mental health and recovery to teach people who are interested (mainly, but not exclusively, other people with mental health problems) in learning how to manage their wellbeing better.

Some of the courses are run in conjunction with a county wide Recovery College, and some are solely for people who live within the conurbation, or area of benefit of the charity. Courses run throughout the year and are repeated at regular intervals. Some are more practical (e.g. Forest School, Felting), others are more about managing the symptoms of poor mental health, such as workshops on self-harm and suicidal thoughts. Alongside the recovery courses, Phoenix also offers support to the other services in Chapter One Wellbeing; staff and peer trainers regularly visit the alternatives to care services as well as

the hospital to provide workshops and training for residents and patients on self-management. They had not done training with staff on either the employment or health and social care side but plans to do this unfolded over the course of the field work.

6.9 Introducing the case studies – Carnarveon

Carnarveon has been providing mental health services since it was established as a Company Limited by Guarantee from the old NHS mental health community care services in the 1980s. At the time of the fieldwork, the focus was on employment services, but this encompassed a broad range of activities, including volunteering, training, formal qualifications as well as advice and guidance for job seekers. There were approximately 40 members of staff, working across a range of different projects. Their offices are in a rural location, housed within a two-story barn conversion, adjacent to a working dairy farm, but within 5 minutes' drive of the main road. All offices are open plan, with the Chief Officer sharing in with other members of the senior management team and administrative staff.

People

Jon –Business Development Manager

Jon joined Carnarveon as a worker on the Fit for Life Project, coming from a background as a music producer. He was motivated to work for Carnarveon because of wanting his working life to make a positive difference to the lives of others. His responsibilities included writing funding bids, leading on marketing and media relations and project management and development across the organisation. At the time of the fieldwork he and his partner had bought an old

farmhouse and were in the process of doing it up. He had a quick wit, a keen eye for observation and was intuitive.

Rachel – Chief Officer

Rachel trained as a nurse and worked in mental health services before coming to work for Carnarveon. She has been with the organisation since its very early days, and in her day to day job manages relationships with external stakeholders and commissioners, as well as taking a hands-on approach to managing and supporting staff. Members of staff were always welcome to come and talk to her when she was in the office, and she made time for them. She was astute, inclusive, funny and straight talking.

Meetings

Whilst I was on fieldwork I was struck by how many fewer meetings Carnarveon had compared to Chapter One Wellbeing. This was in part due to the current context that the organisation was operating in: they were bidding for new money, and also trying to retain a large service contract from health and social care commissioners and also partly due to Chapter One Wellbeing undergoing quite significant organisational change due to the merger which required more frequent meetings. I observed Trustee meetings at Carnarveon, where the Board of Directors met to discuss matters of strategic importance to the organisation, and I observed team meetings and observed several meetings related to establishing a Recovery College in the County.

Places

The majority of the fieldwork at Carnarveon took place at their head office, where I spent time with different projects, in their different rooms in the building.

Most of the work that the staff did was outreach and therefore took place in café's, GP surgeries and other social spaces outside their office building (apart from the self-management courses), and on a few occasions I travelled with project workers and shadowed them in their work.

Conclusion

In this chapter, I have introduced and explained the methods that I used to gather data to refine my programme theories. I used an ethnographic case study approach so that I could observe how and why third sector organisations use research and other kinds of knowledge first hand. My case study organisations were selected to enable me to explore the programme theories further. I collected data using a range of methods (observation, interviews and documentary analysis), and I analysed my data using the domains of knowledge mobilisation programme theories developed in Chapter 5. I developed the narrative of my analysis through coding data, writing it up and redrafting it until I was able to use the narratives to explain the different kinds of knowledge that TSOs use, why they use them (the purpose and goals), and how they use the knowledge (actions and resources). I also introduced my own stance in the research process and explained how reflexivity was undertaken. The Chapter finished with an introduction to each of the case studies. In the following two Chapters, I explore Explicit Knowledge mobilisation (Chapter 7) and Tacit Knowledge mobilisation (Chapter 8) and then in Chapter 9 I use the findings from the fieldwork to refine the programme theory and answer the questions from Chapter 5 of how third sector organisations use knowledge, in what circumstances and why.

Chapter 7 Explicit Knowledge Use by Carnarveon and Chapter One Wellbeing

This chapter explores the explicit knowledge used in the two case studies. The first part of the chapter looks at the different kinds of explicit knowledge created by the organisations and includes what constitutes that knowledge at an individual, service and organisational level, how that knowledge is used and for what purposes at each of these levels. In this way, it is possible to see how the different contexts at which knowledge is created influence or impact upon how that knowledge is used and why. The second part of the chapter looks at the explicit knowledge that the organisations use which they do not create themselves, and how that has been used and why.

7.1 Internally generated explicit knowledge

I defined internally generated explicit knowledge as that which the organisation creates, from work that staff have conducted in the course of doing their duties. Some explicit knowledge was at an individual level such as written care plans, action plans or wellness recovery action plans; some at a service level (for example audit data for different services or impact evaluation reports) and some at an organisation wide level (annual reports, staff surveys). The knowledge was developed through different means (e.g. questionnaires, forms, reports), and was used by staff in a range of ways in the course of doing their work (e.g. developing support plans, activating payment to the organisation). The purpose of generating explicit knowledge internally was so that staff within the organisation could carry out their roles; to enable the staff to understand if their organisation was having an impact and how that was occurring and to secure funding from Commissioners of their services.

In each section, I start by providing a definition of what this kind of knowledge constituted and then go on to discuss how it was mobilised, and why it was used.

7.1.2 Individual level knowledge mobilisation

What is this knowledge?

This kind of knowledge was commonly contained in documents written in the course of a staff member or volunteer carrying out their role of supporting service users. Template forms were used at different stages of someone's journey with the organisation. At Carnarveon completing this paperwork was part of every meeting between a client and the staff member. The reporting requirements of the funders at Carnarveon meant that they needed to evidence every contact event and upload this data onto a client management system, which was the mechanism through which they proved they were doing the work and could, therefore, get paid.

This was not the case so much at Phoenix. Phoenix was funded by Chapter One Wellbeing, and as such, it was independent of a need to keep track of this kind of information for an external funder. Indeed, a key aspect of the recovery learning community at Phoenix was that those there were there as learners, engaged in doing something which they wanted to do; rather than being clients attending services. However, Phoenix did collect some information from people, in terms of their contact details: and if someone attended a course, they were invited to complete an evaluation form for that course. In other parts of Chapter One Wellbeing's services, referrals were used, and paperwork was kept of the 'caseload', and again this was so that the organisation could aggregate such data for performance monitoring and reporting to their commissioner.

I was keen to understand more about how individual level knowledge was captured and mobilised, so I went along with one of the Employment Support Advisors at Carnarveon, to observe an initial meeting between herself and a new client, Adam. The point of the initial meeting was to check out that the person understood what they could get out of contact with Carnarveon, and to gather information from the person on what help they wanted.

So I drove Penelope to Swainbridge, her kit safely stowed in the boot of the car. We got to the surgery, where someone had graffitied the sign 'Swainbridge Healthcare' by adding "*has AIDS*". Penelope said 'I can only apologise'. She went in as I needed to let someone else out so I could park, and obviously, she didn't want to be late. We were meeting her client in a GP surgery, which looked single storey, although wasn't as it goes, judging by the rumbling of footsteps overhead during the conversation. Penelope signed us in and then the nurse said our room was free, and that the client had arrived. Penelope went and got another chair, as I went into the room and took a seat, and the client sat on a computer chair. The room was a small clinical broom-cupboard of a space with a small window, behind where I was sitting, which would look out onto the carpark.

Penelope invited me to introduce myself to him, so I did, I explained about the project and why I was there (*to see how Penelope does her job*). He was happy about this and content for me to sit in. Referrals for this service come through GPs, and the GP that had referred the client we were to find out was a 'good one', as he'd also referred the person on to other support services.

So the three of us sat down and Penelope started by explaining a bit about what the meeting was for - essentially to work through the paper work (referral, participant agreement, 2 wellbeing scales, whole life signposting and action plan), and that by the end of it they would have agreed on some things that could help the client to move forward.

Adam told his story, saying he lives in a caravan, where there's a farm house, and a bar on site, literally (showed us photos), said early on that he drinks alcohol, and is alcohol dependent, drinking alone in the park during the day. He said he had an appointment to go and see Addaction that afternoon.

Penelope sat at right angles to Adam, and she filled in the paperwork, she held the pen, she checked things off with him, and she used the questions, particularly on the wellbeing scale, as a way, a tool, for him to be able to talk about why he was having the conversation with her in the first place, about his current circumstances. And the chaps story, we don't know the full story, apart from his Doctor thinking he has depression and his daughter encouraging him to seek some help; he was working up until September last year but doesn't feel ready to return to work just yet. And that's because he was quite upfront about having an alcohol dependency. This didn't phase Penelope at all, she seemed

content he was getting support from Addaction, so that was good, and not a barrier to whether he can get help from Carnarveon.

So she took him through the referral form, making sure the details were correct making sure he understood what the purpose of the conversation was about. She looked at the participant agreement form next, she said that was basically setting out what he can expect from them, she explained very carefully where the data on him would be held, who it would be held by, where it would be kept. That she would only refer to him by his initials, and that she would keep his paperwork in a locked filing cabinet at work, or it would be in a locked case, and the only thing that had his name on would be the referral form and she asked him to keep her up to date if his details changed. Throughout the conversation, she was sitting slightly forward in her chair, engaged, and open, with her paperwork on her knee, her body language felt authentic and genuine, like she genuinely was present, there in the room with him.

Penelope said about how the participant agreement underlines that this is a workspace, that we agree to behave as if we were at work. Adam didn't have any issue with that at all, said that would be fine, he'd already at that point said about his alcohol dependency, and Penelope made it clear that if he wasn't up for a meeting to let her know, text, to reschedule, but that basically, she couldn't work with him if he wasn't sober. So she explained a bit about Carnarveon and the options and what might be available. She took him through the first questionnaire, asking about feelings over the last two weeks, and to rate on a Likert scale the extent to which he agreed and disagreed with statements like "I feel confident meeting new people" (I think it was the Edinburgh-Warwick scale). Under each rating, there was space to write a few comments, and she invited him to explain why it was that he felt that way.

That questionnaire acted as a good tool and opportunity really for him to share a bit about his experience. Penelope didn't ask counselling type questions, but she did probe for detail on his previous work experience and things like that. They spent about 15 mins on that particular questionnaire. Adam didn't look uncomfortable, he was open, and his body language was open. I think he appeared to be mildly hopeful that somehow this might make a difference.

Towards the end of the conversation, he said *I just need the Doctor, Addaction and you to tell me what to do*. And Penelope picked him up on that and said *it's not really about that, it's about giving you choices and you deciding, not about us telling you what to do*. He nodded slowly, a bit unsure of what she was saying.

One of the things that came out of the questionnaire was how socially isolated he felt. Penelope said what they could offer to help him meet more people, to feel more confident in those situations. It turned out he was very unconfident being around people he didn't know very well and hadn't always been like that, but he now felt paranoid about people in town talking about him, which was making him avoid situations and being around other people. And increasing his isolation.

So we looked at the second well-being scale. It felt shorter, there wasn't as much chatting. He said that he viewed the alcohol as a coping mechanism. He

saw it for what it was but saw it positively - *I have nothing else if I don't have that how on earth will I cope. It's all I have.* Penelope didn't enter into that dialogue, but acknowledged it and jotted it down on a piece of paper. Then they moved on to the 'whole life signposting', which is basically one side of A4 with a series of boxes around a circle. And each box represents an aspect of your life, and the idea is to look to fill each box. Penelope asked him *Tell me about what you've done previously. What work you've done. Your training and education needs.* Turns out the guy had left school as soon as he could, didn't get his GCSEs, but had actually done an English and maths course at the learning centre. And Penelope knew the centre and what qualification he'd got, so she was able to jot the proper course name and centre down on the paper.

Under the social aspects box, she talked about a project based at a Horticultural Nursery, run by the local College that offers therapeutic opportunities for people with mental health problems, to come along and learn some skills, get some training and certificates. Adam used to work on the railways, and Penelope knew about a steam railway community project, which he might be able to volunteer at, he said Yeah. He was very accepting of what Penelope could offer him, didn't turn her down at all. Penelope explained there were other projects, enablement, and when he was ready the employment project, and I think she didn't bombard him with information, she was good at listening, there weren't any long awkward pauses, but she didn't rush him or force him, she gave him time to speak and share his mind.

She gave him some information to take away, a photocopied folded sheet of paper. The conversation wound up with Penelope jotting down some actions and saying she'd send it to him and that they would meet again in a few weeks' time.

Fieldnote 28/03/17

The purpose of this meeting was to gather individual knowledge to help design what would support the person on their recovery journey. In this instance, the forms acted as the starting point of that journey, setting out that the focus would be on Adam's knowledge of what would help him, and capturing that in ways which meant that over time, both the service and he could see the progress made. However, people did not always know what they might need, and instead were looking to be told what to do. Some of the people who came to them had little experience of using their own knowledge of 'what works', and for some, even being given the option of deciding for themselves what they wanted to do was novel. This way of working, of focussing on what the person knew and wanted and tailoring support to meet their needs as best as they were able

was a principle approach used by both organisations, but it was adapted in these initial meetings to meet the needs of someone who might not feel empowered yet to take responsibility for their recovery journey.

In this example, Penelope provided Adam with a range of options of activities and routes to work which he might like to try. She suggested ideas and encouraged him to think it through for himself. She did not force him or say that if he did not do what he was told then he would not have a service. She used her knowledge of what might have worked for others, and what was on offer locally to help Adam, whilst also refusing to tell him what to do. This was a principle approach I saw at both organisations: the focus was always on the person themselves making decisions, and then being supported in whatever way possible by staff and their resources.

I asked one of the other vocational workers at Carnarveon about what they did when someone was starting with them but did not "know" what they wanted. He explained that a primary value of the organisation is to support people with mental health issues to *move forward in their lives*, and to do this in the most supportive way possible, focussing on helping the person lead the process themselves, giving them ideas and options, but ultimately basing decisions on that persons own knowledge of what worked. I asked how people responded to this, and he said:

Most people are quite surprised. I think sometimes people have been in the system so long they're used to being told what to do and I go there and say I'm here to do what you want to do, they look at me blankly and say I don't really know, and then we start working together and looking at it. By me asking questions about what they want... I mean, I've got a referral, so I have a vague idea of what they want. But it has to be about empowering people to do what they want," [CS2ID02]

I shadowed another vocational support worker and saw similar processes again, and afterwards I asked what it was they were doing in these 121 meetings, and she replied: "We're helping people, but really, they're helping themselves; I don't know what I did really, it's not CBT [Cognitive behavioural therapy], yet it works." (Fieldnote, 16/05/17)

At this individual, one to one level, explicit knowledge (the forms, the whole life plan), is gathered in to inform what will happen next: the opportunities and next steps to 'move forward'. Being able to provide such explicit knowledge of what will work is dependent upon the person knowing what will help them, but even if they are not sure, staff are able to use their experience and skill to support the person in making those decisions and developing this individual level knowledge.

Why is it used?

The knowledge gathered at this level served several functions: ensuring the person got what they wanted out of the contact with the particular service, evidencing that a contact event had taken place, so the organisation could get paid and being a baseline to refer back to during the journey which showed how far the person had come, and what improvements they had made. Overall, individual level knowledge was used to deliver the services of both Phoenix and Carnarveon: without knowing the people that come along, then the services were unable to support them effectively. This reflects an important point in terms of thinking about the purpose of the services: at both case studies, they were emphatic about doing whatever they could to help the person move into living the life they wanted. The purpose of gathering individual level knowledge

was to create a plan for that person and then to wrap what was available around to meet that need, rather than expecting the person fit into and respond to whatever was on offer.

How is it mobilised? What are the actions and resources used?

At Carnarveon, individual level explicit knowledge was mobilised in different ways depending on why it was being used. If it was to evidence that a contact event had taken place and to facilitate payment to the organisation, it was uploaded onto the Client Management System. If it was to provide a baseline for the person to refer back to and see how far along their recovery journey they had come, then it was shared with them verbally and in writing at their meetings with a project worker. If it was to create the wrap around plan of how the person was intending to move forward, then it was mobilised through 1-2-1 meetings between the client and staff, or through 'corridor conversations' at the base, at team meetings, or via email.

There were instances of staff emailing the team and explaining that they had someone with a particular interest or need and asking for help. The rest of the team were responsive, and would suggest people, or projects the worker might like to approach to help. There was a global email address for all staff at Carnarveon, and so if anyone had a question about helping someone, they would email round everyone asking for input, as these excerpts show.

Subject: Help with info please

Hi

I have a client who would like to access some surfing and horse-riding lessons. She is quite anxious but wants to step out of her comfort zone and give herself a challenge and would like lessons somewhere where they will be understanding of her anxiety and possibly being tearful. Has anyone had any

contact, either themselves or through clients, with surf schools of horse-riding stables who are perhaps particularly gentle and supportive?

Thanks for your help.

Best wishes

Email 21/02/17

Subject: Illustrators?

Hi All

I am working with a client in [town] who has a degree in Illustration and wants to eventually find employment as an illustrator. She completed her degree approx. 2 years ago and is gradually getting her portfolio together. Do any of you wonderful people know of any illustrators who might give my client the chance to have a visit/have a chat about how they started and where they get their work from. Any advice information gratefully received.

Thank you

Email 06/03/2017

This approach to sharing individual knowledge and then drawing on staff knowledge from the whole team to help an individual was something I saw at Phoenix as well; although the work at Phoenix was much less structured around moving forward and was more about belonging and connecting. At Phoenix, it was most often manifested in the "morning talk" of the office prior to the self-management courses kicking off, or in the "debriefs" at the end of the day, when peer trainers would share with each other about who had come along, and what had happened. Phoenix was intentional in building a recovery learning community, and so talking together to share individual level knowledge (generally their own) of 'what works for me' was a key aspect of this process.

7.1.3 Service level knowledge mobilisation

What is this knowledge?

At a service level, internally generated explicit knowledge took the form of impact and evaluation reports and audit and monitoring data. Chapter One Wellbeing and Carnarveon had produced their own evaluations of particular

services and had used these to re-design what they did and how they did it.

The audit and monitoring data was, for both organisations, part of the reporting regime, and a mechanism for getting paid for their work. Both kinds of explicit knowledge were also valued by the organisations in terms of how they helped them understand if and how the organisation was achieving impact.

Impact and evaluation reports: Crisis House Impact Report

Chapter One Wellbeing and Carnarveon both had reports written up by staff on evaluation work which they had undertaken on particular services. Before I started my fieldwork at Chapter One Wellbeing, Chloe, the Business and Innovation Manager sent me through a copy an Impact Evaluation Report on their mental health crisis house service. This twelve-page report outlined the approach used, the model of care and the impact of the service on people's recovery. It was written in plain English, and was visually very appealing, with different colours and boxes of text, pictures and photographs too. (See Fig. 5)

Within the report, there was a section that explained how "We are keen to expand our preventative support provision and early engagement reach, with a focus on developing non-accommodation-based sanctuary alternatives to crisis admission." [Chapter One Wellbeing, 2016 p12]. Some staff had visited another Crisis House in Leeds to learn about the 'Sanctuary Model', where the house acted as a hub for Recovery Self-Management Courses, as well as a crisis support. The report ended with outlining the future vision and plans: to become better at capturing evidence of outcomes, and to be able to provide more in-depth evidence of longer-term impact.



Figure 5 Impact Report

Phoenix Evaluation

Whilst I was with Chapter One Wellbeing, I undertook an evaluation of their Phoenix service. Anthony and Louise were talking about the Acute Care Pathway meeting, and how it had come up that the Commissioner was interested in knowing what difference Phoenix made to those that attended. Chapter One Wellbeing had given a presentation on what was going on at

Phoenix to the Acute Care Pathway meeting, but the group were keen to understand the impact of Phoenix so that a case could be made for it receiving funding from the Clinical Commissioning Group. Knowing that they were short-staffed and that Chloe was very busy with evaluating other parts of the service, I offered to help. I had been doing fieldwork at Phoenix and learning about the services there for almost three months and knew many of the Peer Trainers well by that point. Anthony and Louise were really pleased, with Anthony telling me later when it came up in one of his interviews that part of the value of me doing the evaluation was that it was therefore objective:

[...] done by someone who is not an employee or directly related to the delivery of the service, that's what I meant by objective. And also, that you know what you're doing, or at least you look like you do. You approach your work with the discipline of what you're expected to do, and experience and clear ability, so in that sense it was proper. And that adds value.

Interview, Phoenix Offices, 07/12/16

We talked over what the piece of work should focus on, and in discussion with some of the Peer Trainers, set up an interview schedule. I spoke to some of the Peer Trainers a couple of weeks later about the service at Phoenix and did a simple thematic analysis of the interviews and wrote it up into an 8-page report (Appendix 8.) The evaluation found that the Peer Trainers initially came to Phoenix to find a sense of purpose and meaning in their lives and to learn how to manage their mental health better; once they had started to achieve this, they wanted to be Peer Trainers to give something back to others. The culture at Phoenix was described as being “a family that you didn't know you had”, and a place where people felt accepted as they are, with the only pre-requisite to attend being a desire to start or continue their recovery journey. The kinds of

outcomes that people said they achieved through being part of Phoenix are shown in Figure 6, some of these were directly related to what they had learnt on the courses, and some were as a consequence of being a volunteer Peer Trainer and part of the community at Phoenix.

Mental health and wellbeing outcomes

The mental health and wellbeing outcomes that participants told me they were achieving through being at Phoenix included the following:

[LO=Learning Outcome]

- learning what works for me and how to take steps to support my mental health (LO)
- increased self-awareness (LO)
- sleeping better (LO)
- coping better with triggers (LO)
- how to challenge negative thoughts (LO)
- how to increase focus (LO)
- valuing personal lived experience and self-acceptance (LO)
- able to say no and be more assertive (LO)
- understanding my diagnosis better (LO)
- understanding others better: particularly self-harm (LO)
- different coping strategies (LO)
- to be more open and trusting with people
- managing to deal with long term, underlying emotional issues which had previously felt and been intractable
- feeling valued and worthy
- learning to recognise personal progress
- having a sense of purpose and meaning to life, a reason to live
- how to sustain my recovery
- recognising that I don't have to fake who I am

Figure 6 Mental health and wellbeing outcomes

How was it mobilised?

The Impact Report on the Crisis House was shared with their Commissioner, via email, and was then discussed at a Performance Monitoring meeting, as part of Anthony making a case for changing what the crisis house offered to local people. The Commissioner was proud they had a crisis house in their district, as a lot of areas had closed theirs due to funding constraints, and initially did not seem keen for it to change too much. However, the Commissioner seemed content to let them try something new and after the meeting, Anthony said he thought the Commissioner would have been reluctant to allow them to make any changes to what was on offer if they had not got explicit knowledge within which to ground their changes.

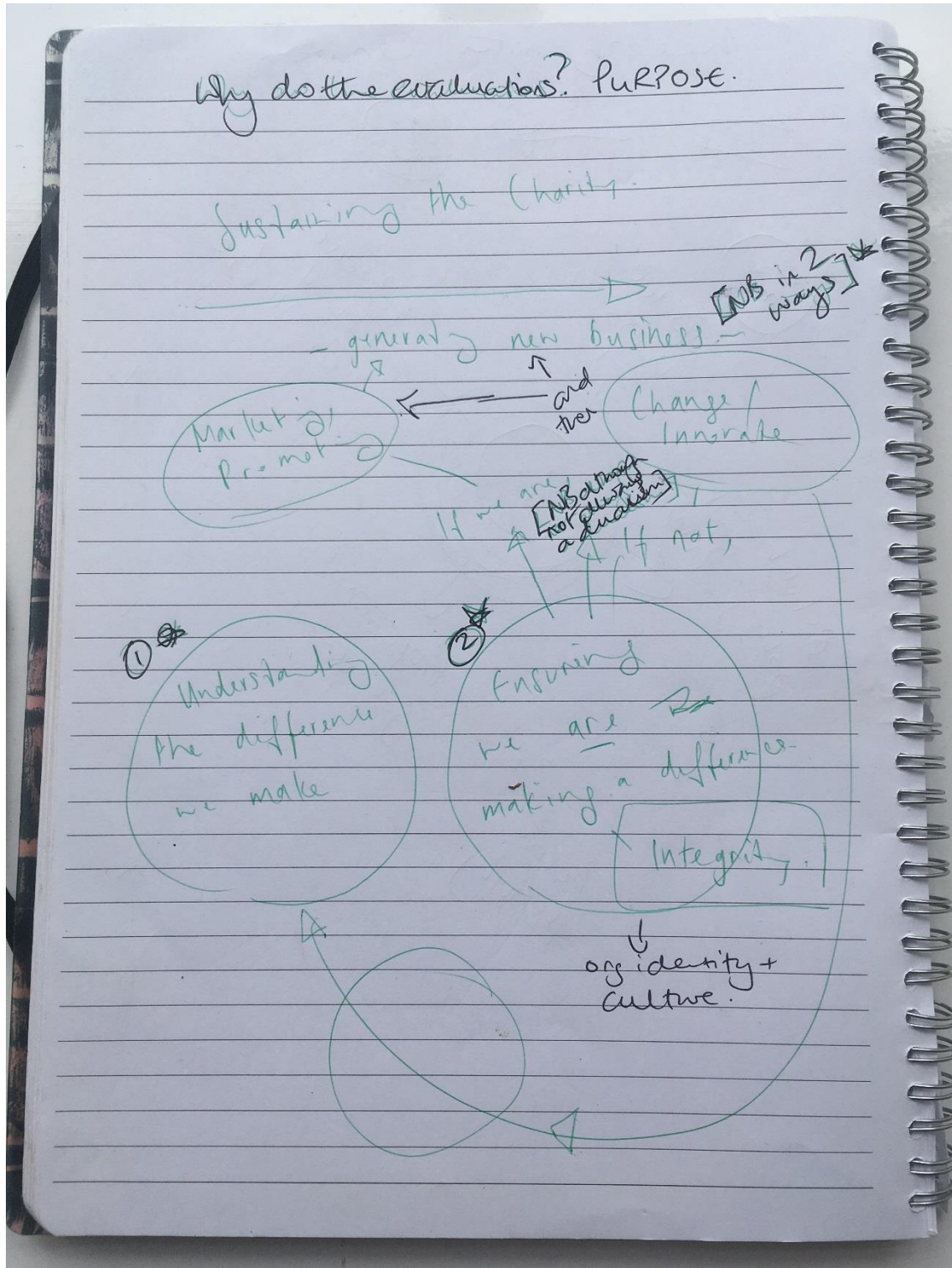
Louise shared copies of the Phoenix Evaluation with the Peer Trainers and Anthony emailed a copy to the Acute Care Pathway Group. Unfortunately he was unable to attend the meeting where it was discussed, but in an interview towards the end of the fieldwork he said the report had been used in several ways: as something which validated the claims they had been making about how Phoenix worked and how effective it was, in that people learnt ways of self-managing that then had a positive impact on their ability to lead the lives they wanted. He added too that the evaluation was welcomed by the Peer Trainers and Louise, as an affirmation of what they were doing, and because it showed that what they were doing was being taken seriously (by those within Chapter One Wellbeing, as well as outside the organisation). He said that the report was turning into a tool for promotion and explanation of what was going on at Phoenix.

Why are Evaluations and Impact Reports used?

After I had been at Chapter One Wellbeing for a few months, I met up with Chloe at a café near their head office, and asked her about the Impact Reports and evaluations they had carried out: what motivated them, and what were they for? She drew me a picture to explain and describe how they came about and what they were intended to achieve (Figure 7). As she drew, Chloe explained that the overarching purpose was to look at ways to sustain the organisation through generating new business. This was achieved by evaluations in two ways: through understanding the difference that a service was making, and to also ensure that the service was making a difference. She linked this to their integrity as individuals and as an organisation; explaining that their mission and values were all about meeting the needs of people with mental health issues, and these values were really important and foundational to what they did and how they did it. She went on to say that if they could prove they were making a difference, then the impact reports could be used for marketing and promotion, but if they found they were not making as much of a difference as they wanted, then this would feed into changing and innovating within the service.

In an interview, Anthony explained that the purpose of the Phoenix Evaluation was to provide them with evidence of what was going on at Phoenix, with a view to the service potentially being funded. Some kind of evaluative work had been asked for by the Acute Care Pathway Group, and the evaluation was their response to it. What was particularly interesting to us both, was that despite this, after the Evaluation had been shared, the Commissioner emailed him saying that whilst it was all well and good, what was really needed was a sense of the *numerical* impact the service was having: how was it reducing A&E attendance, or GP appointments? Anthony reflected that for him this was

Figure 7 Purpose of evaluations and Impact Reports



symbolic of where mental health services were at the moment: was not necessarily about what was happening for people who attended, but about the money. He was unbowed by the Commissioner's response, feeling that the report is one of a series of steps which needed to be taken to influence the

frames of reference around what is commissioned and why. He felt now that the report was one small step along that journey, but nevertheless, he thought that it was an important one.

What Anthony was getting at was something he had talked about before: that the way that outcomes are measured in mental health often does not correspond with what people with lived experience find meaningful, and how outcomes set out from forces external to the organisation have the potential to derail the effectiveness of what a service is doing: it was important for Anthony and the others at Phoenix to know *how* Phoenix worked as well as what it did and how that impacted on the NHS system locally. He thought that without knowledge of how the outcomes that were occurring were produced, there would be little hope of creating them in other Chapter One Wellbeing services (something which he felt very strongly needed to happen).

He was thoughtful about the journey which they had had to take to get their Commissioners to understand what they were doing and why *how* they did it mattered so much. He also said that it was not just about those “out there” understanding, but about staff across the organisation understanding that the evidence base for what they do needs to be firmly rooted in the experiences of those that use their services. He had attended the newly developed staff induction day the day before we spoke and said that even there, there was a need to develop the culture to be much more thoughtful and centred on people with lived experience of mental health problems, using their knowledge and experience to guide what the organisation did.

I visited Phoenix over a year after I finished the fieldwork to find out from them how things were going and was told that the evaluation of Phoenix was now being developed into an outcomes framework for understanding and measuring the outcomes in other parts of the organisation. Phoenix was still not commissioned by the Clinical Commissioning Group, but Anthony seemed to think that was a good thing. He had said in a previous interview that there were other potential funding streams, outside of CCGs, which they could apply to for Phoenix, but that he was nervous about being too tied in to outcomes that came from outside the organisation, saying " I'd rather go without the money than have some artificial targets to be driven by; so I'm cautious about that." (Interview, 07/12/16) He said it meant they could remain independent and able to continue to let Phoenix develop in its own way. He added though that this had not obviated the need for a more quantitative evaluation for Head Office: Phoenix was still being funded directly from the Charity's reserves, and evidence was still needed by the Senior Management Team and the Board to show how it was having an impact.

Doing a study within a study.

I was aware when I first heard the team talking that morning about the need for an evaluation that if I offered to do it, and they accepted, that might have implications for the rest of the time I was to be with them. I am not sure that I completely shared Anthony's sense that what I could produce would be more objective: I had already been within the organisation for a few months by the time this opportunity arose and was already well known and liked by those there. What I could bring though was my research and evaluation skills of

systematic approach and rigour in the way the interviews were carried out, and how the data was analysed. I also wanted to use it as a bridge to find out more about how the peer trainers worked, their individual knowledge and their experiences of being at Phoenix.

I spoke to one of my supervisors to see what they thought, and they felt it was okay for me to do the work ("so long as you have the time to") and knowing that I had already flagged up in my ethics application that talking to volunteers may include people with lived experience, it felt ethical for me to do this work. It changed the research and fieldwork for me in the following ways:

I became more aware of the range of outcomes which Phoenix was achieving without, it seemed to me, basing what they were doing on research evidence. This led me to speculate and theorise about why different kinds of knowledge are needed by TSOs, and by different services and individuals within those TSOs. I knew it would help me understand my programme theories in a deeper way.

I felt my work had 'buy in' now from the staff and volunteers; prior to this, I think they were vaguely curious about what I was doing, but being able to give them something (The Evaluation), felt important and valuable on two levels: it was a way of giving back something to the organisation to say 'thanks' for allowing me to do my work with them, and it also felt good because I saw how keen they were to learn about how Phoenix 'worked'. I think that this transaction, of me giving them something they wanted, meant they were more interested and open to what I was doing. Prior to conducting

the evaluation, I had already felt like I was acceptable, following the evaluation I felt accepted, and "one of the gang", included in other conversations and discussions to do with developing the services at Phoenix which may not have happened if I was still on the side-lines observing.

Audit and monitoring data

For the Health and Social Care services of Chapter One Wellbeing, their main business was conducted at either the Referral and Governance (R&G) Meeting, or the Health and Social Care Senior Management Team (H&SCSMT) Meeting. They used to have just one meeting until those meetings became so long (3+ hours) that the Director of Health and Social Care took the decision to move topics that were about corporate business and staff management out and into a new meeting. Nina chaired the R&G meetings, as Clinical Governance Manager, a nurse by background, she had worked at or managed most of the health and social care services of the organisation, so was in a good position to take the lead on clinical governance.

One of the main activities in the R&G meeting was to review bed occupancy, and so managers prepared tables which gave details of individual patient names, NHS number, date of birth, what area the person came from, type of admission, date of admission, planned discharge date, and revised discharge date if the person was staying in longer, who the recovery care coordinator was, (someone external to Chapter One Wellbeing that worked for the local NHS mental health services) and, if discharge was delayed, an explanation of why. Much time was spent discussing individual patients and their care and progress through services during the meetings; checking the accuracy of the information,

telling the stories of the people within the services, working out the best way to help the person.

How was it mobilised?

The papers for the meeting were routinely emailed in a zip file and consisted of an action log, agenda, a file on activity towards achieving the CQUIN, policies, audit updates, staff education and development, relevant NICE guidelines and miscellaneous documents that were tabled for discussion or action. Each of these topics would be discussed at the meeting, and the zip file contained explicit knowledge to enable the conversation and action planning. A peculiar problem experienced by H&SC staff was that their web-based email sometimes stripped attachments off emails, and so often people would arrive without having had a chance to read and digest the documents. Or even if the attachment did come through, the number of papers to print off and bring was too great and took too long, and so at these meetings, time was taken to read through the papers before the meeting commenced.

Why was this knowledge used?

The cumulative value of this explicit knowledge was that it was used in contract review meetings with their commissioner. I attended one of these meetings and observed to understand how this was done. At the meeting, the agenda was to discuss the Performance and Activity report which Nina had produced, and to then look at what it meant for how well Chapter One Wellbeing was providing the services, and what changes needed to be made. Staff shared their knowledge on how the services worked and why it was that people might be delayed in leaving a service: often to do with a block or a decision needed

elsewhere in the local healthcare system. The reports provided evidence to show the Commissioner what was happening, and how well the organisation was performing. Episodes of care were the way that the organisation was funded in part, and so understanding what was happening, and how and whether patients were using services appropriately was an important aspect of the organisation accounting for their activity and being paid for it.

7.1.4 Organisational Level explicit knowledge

What is this knowledge?

At an organisational level, internally generated explicit knowledge took the form of whole organisation reports for commissioners, and surveys. In both organisations, generating explicit knowledge at a whole organisational level was seen as an important task. Carnarveon used to have a member of staff whose role was specifically research and evaluation, and who would have been in charge of conducting the survey and writing up the results, however after she went on maternity leave, the role was not recruited to and so they did not have dedicated capacity to do the survey. Chapter One Wellbeing did not have a dedicated research or evaluation officer, although it was an aspect of Chloe's role.

Staff Survey

The original CCT survey, first conducted in 2014, was developed by one of the service managers and focussed on whether staff felt safe, whether or not they thought the service was effective, and whether or not they thought the services were well led. Since then, the survey had evolved and was now based more closely on the NHS staff survey. In April 2015, they were mandated by their Commissioners to conduct a staff survey as part of achieving their CQUIN

target and get paid: a proportion of their block funding was held back by commissioners, and only released on the production of evidence that the organisation has carried out specific tasks to meet agreed outcomes.

How was this knowledge used?

The findings from the staff survey were discussed at the Organisational Development Group meetings and at the Referral and Governance Meeting. At the Organisational Development Group meeting, staff were given the results of the survey and asked to start thinking through appropriate actions or activities that needed to happen to address the survey data. Sitting round tables in the large meeting room, the staff were taken through the survey results step by step by the Finance Manager, who then invited those present to read and reflect on the findings and discuss in small groups what they were doing well as an organisation, what they should be doing better, and how they would go about forming an action plan.

Each table had two sections of questions to focus on and had a print out of the findings from the survey for those sections. Sitting in silence, staff read through the findings and then began to talk about what actions were necessary. The print outs were not straightforward to understand, and it was not immediately clear to those round the table what they meant, so it was difficult to start action planning. Two members of staff had taken the survey findings and produced the reports for the ODG, but the reports were not clear, and it took time to understand them. Each table wrote up on some flip-chart paper what they thought about the findings, and what kinds of actions should be taken, and these were gathered up by the Finance Manager at the end of the discussion

period, with a promise they would be fed into the action plan which would then be sent to managers.

The whole agenda item took an hour from start to finish. Staff were engaged and seemed to be keen to give their views, however, at the next ODG, when the Chief Exec invited people to recall what had been discussed at the previous meeting, not one person could remember that the staff survey had been a topic. At the following Referral and Governance meeting, the staff survey was revisited as part of the discussion on achieving the CQUIN, and by that time, an action plan had been created.

Why was this knowledge used?

For Chapter One Wellbeing, the staff survey was part of how they fulfilled the requirements to achieve their CQUIN and get funding, having been identified nationally as a CQUIN target. Gathering of views through the staff survey was seen as being an important way to take the temperature of the organisation, particularly as there had been a lot of organisational change over the past couple of years. The Chief Executive felt that doing a staff survey was a way to set culture within the organisation too, through showing staff that their views and experience mattered.

Clinical Commissioning Group Report

At Carnarveon, their main contract with the Clinical Commissioning Group was under threat. They had received signals that this was the case the previous April when the funding was renewed, and now the changes were on their way. Health and social care commissioners locally were working to try and decide

what funding might be available, and whose responsibility it was to fund the organisation. Carnarveon had been quick off the mark in helping the commissioners by producing a 108-page report, written up over a weekend by two senior management team members. The report set out in research-backed detail, what the organisation did, what its social and monetary value was and how it compared to similar services. The report was packed with tables, financial data, qualitative data, all emphasising and re-emphasising the positive work the organisation does, and the weight of its impact on the local population and economy. Much of it was drawn from a 2013 publication by the organisation, conducted by the then Evaluation Officer.

How was it mobilised?

This report was sent to the commissioners as evidence of how the organisation was performing, and the value it held not only to its clients but also the wider economic vitality of the county. Following this, a few weeks later, on a Friday afternoon, Rachel the Chief Executive was waiting for a phone call from the commissioner to let her know how the meeting with the council had gone. The problem about their funding had been identified as being one of ownership: to whom did the funding of "support to employment, education or volunteering" of people with mental health problems belong? Was it a health matter, or a social and welfare matter? And this was set against a context of decreasing budgets for adult mental health and adult social care. The wrangling had been going on for weeks, and although the health service commissioner seemed hopeful of a positive outcome, there were no guarantees: both sides had to come to an understanding about what was to be done.

Why was this knowledge used?

Jon had said that the report was useful in demonstrating the case for keeping the organisation, but Rachel said it was really about the way they had conducted themselves as an organisation during this time that was important. Research based knowledge for the commissioner was not thought of as being the final word on whether or not they would be funded, rather, they felt it gave their commissioner bargaining power with the council over what could be done. The phone call came. Rachel's expression grew briefly stormy, and her brow furrowed ever so slightly. She did not speak much, and when she hung up, she said "Monday." The room breathed a collective sigh of frustration. This was the end of the second week of waiting, each day bringing the promise of a resolution, but each home time the tension remaining.

However, the following week, the agreement came through for another year's funding, with a view to a longer-term contract being awarded following a competitive tendering process the following year. But how had that decision been reached? I asked Jon about the impact of the report in an interview and he said

[...] the factors which got us re-funded? Our reputation, that we'd been doing pretty good work for thirty years, there are enough people who are part of that decision-making process, who know that experientially. Relationships between the senior management team and Rachel especially, with the commissioners, and the respect that exists and created a culture where the people who make that [funding] decision wanted to find a solution. The report gave them a tool to back up their gut feeling about it. So the mental health lead in the Clinical Commissioning Group, the report allowed him to defend Carnarveon to other decision makers: *here's their work.... here's the stats.... here's the Warwick-Edinburgh tool which we should all respect.* I don't think the report changed hearts and minds but gave them a tool [...] I do think it was valuable and was part of the solution, but without it, I suspect a solution would have been found.

Interview Carnarveon 180517

Jon was describing a tactical approach to explicit knowledge use:

understanding the transactional nature of explicit knowledge mobilisation.

Carnarveon had to produce knowledge which their commissioners could then use, without it, it would have been more difficult for the Commissioners to negotiate their funding. But the reason why the Commissioners wanted to negotiate their funding was to do with Carnarveon's long term organisational reputation and relationship with the Commissioner, rather than purely because they had produced a long report of explicit knowledge which said they were effective. The explicit knowledge was necessary, but not sufficient to support their case for funding.

7.2 Externally generated knowledge

What is this knowledge?

The initial rationale for conducting this research project was to explore how research-based knowledge was used in practice by TSOs. Research-based knowledge was initially conceptualised as knowledge from academic, University-based research, generally produced in journal articles. However, in the course of the work, this conceptualisation grew to encompass other explicit research-based knowledge outputs, such as impact and evaluation reports, or 'grey', non-peer reviewed literature, newspaper articles, documents associated with funding opportunities and Government Policies, and was derived from websites, think tanks, policy briefs, evaluations of other similar services and so on.

How is it mobilised?

When this kind of knowledge was mobilised in the case studies, it was generally done via linear means, such as email, or printing something off and showing it

to someone else, or cutting and pasting words, pictures or tables into other documents. At Chapter One Wellbeing, Chloe did a regular email round the Executive Team of business opportunities, policy highlights and research-based reports which she had read in the course of her work. She read the reports, gave a brief summary of what they contained and what the opportunities or implications might be for the organisation, and included a link to the actual document or article.

Why do TSOs use externally generated explicit knowledge?

In the two case studies, this kind of knowledge was used ad hoc to make their case for future funding and to increase the sustainability of the service or to provide content for the self-management courses (which is discussed in the following chapter.)

The main purpose of this email round-up was to keep the Executive Team abreast of developments in their field and to look out for funding opportunities. I was copied into these emails, and towards the middle point of the fieldwork at Chapter One Wellbeing I asked Chloe a few questions about the Business and Innovation Updates, as they were called. She said that the motivation for the Updates was to feed in relevant information to support their Executive Team with organisational direction and decision making. She listed a range of different approaches she used to find information that might be relevant

- Regular web scanning for news and information (e.g. ERSA, NPC, The Work Foundation, The Health Foundation, The Mental Health Foundation, Gov.Uk mental health service reform, The king's fund, NHS Confederation, Devon Partnership NHS Trust, British Association for Supported Employment, The Learning and Work Institute, Reform,

Carley Consult, Heart of the South West LEP, Russell Webster, Indus Delta, etc)

- RSS feed
- Email subscriptions
- Networking events/ conversations
- Recommendations from others
- LinkedIn

When asked about how she knew what to include and what to miss, she said: "I make a decision on what's relevant to us through a combination of keeping an ear to the ground internally and being aware of what's happening and developing externally in the sectors." (Chloe, Email Correspondence, 25/10/16).

I asked her about how she knew that the update was finished and ready to send (considering that there is always more knowledge that could be added), and she replied that it was when it was time to go home. As one of the supposed problems with using explicit knowledge was how to locate and then access it, I was curious to know if there was ever information that she'd like to share but found difficult to find, and she said not really. Finally, I asked her about how the Executive Team responded to the Updates: did they take them into account and use them? Did they give her feedback? She said that she attended the Executive Team meeting and also has one-to-one with the Chief Executive every month where they follow up on relevant points, if not before. However, the contract opportunity appraisals (where Chloe would give a summary of a new funding opportunity and suggest how Chapter One Wellbeing might fulfil the tender), had a much quicker response rate from the Executive Team, of generally a few days.

In all her answers, there was no reference to assessing and judging the quality of the explicit knowledge in the way that an academic might approach the task (validity, reliability, methodological integrity and so on). Instead, quality was judged based on either where it came from (with organisations like The Kings Fund being seen as reliable sources of knowledge), or on how useful it was for their organisational purposes, such as sustainability.

Academic Research-Based Knowledge Use (ARBK)

Whilst I was with the case studies I did not witness routine incorporation of ARBK into their activities. ARBK was not accorded greater status than other sources of knowledge. But I also did not see it being referred to as irrelevant or at a different level, as found by the pilot survey findings. Instead, it served a function for the organisation when they wished to “evidence” something. So using ARBK in the self-management courses as discussed in the next chapter, was universally felt to be a good thing and worthwhile, but ARBK was not systematically considered in organisational service improvement. Staff attitudes towards academic research-based knowledge are discussed in more depth in the following Chapter on tacit knowledge, where ARBK provides a counterpoint to the experiential knowledge held by staff. With both organisations, however, academic research-based knowledge was thought of as important, and valuable, but it was used in a more ad hoc way, (*I wonder if there's some research we can use to back this up?*), rather than a systematic point in a process of decision making.

Anthony and I were talking about how the organisation used research in its work, and he said that he knew that using research was important to ensure

that what was done was the most effective use of the resources they had, and not based on a whim of a member of staff. At the same time, he said realistically, they already knew what the needs were and so what other evidence would they be looking for? He gave an example from one of his history lessons from school, of learning about archaeology in the 19th Century, and about a chap who dug through many layers of Troy before he declared he had found it. Anthony said that this story had stuck with him because of how the evidence of what he was looking for was already staring him in the face: he wasted time and effort digging for something which if he'd paid attention, he would have noticed.

What Anthony and I had done in this conversation was to miss each other's meanings: I was interested in academic research-based knowledge use in this instance, whereas when I said "research", he thought of the internally generated research which they did as an organisation for themselves to understand their community. Unfortunately at the time I did not realise we had misunderstood one another, which in itself is a point of reflection in writing this: that even after becoming sentient to the problems of misunderstanding what counts as knowledge, and what place research has for an organisation, I could still miss the opportunity for an important clarification and follow up question. What it also showed was that the role of ARBK was not foremost in his thinking: when Anthony thought of research, he thought of it in terms of understanding community need and internally generated.

At the other case study, during an interview, I asked similar questions about the place of ARBK in the organisation and was told that in their current climate, with

uncertainty about funding, the focus was on core activities to ensure service delivery. Jon likened worrying about research and research use as being like doing topiary in the garden when there's a hole in the roof of the house. I pushed him on this point, was research really topiary? He replied that research was about improvement, and "When your back's against the wall, you're looking at stopping yourself going backwards, rather than improving going forwards." However, he also pointed out that this in itself was insufficient too: there was always a need, he said, to know your market and promote your organisation. However, until they were able to build in full cost recovery on all their contracts, they would simply be unable to afford another evaluation officer. I pressed in again and asked whether that meant that having a research and development function was dependent on external factors, rather than an internal decision to invest come what may. He agreed but said that he did not think it ought to be the case and that using research and doing research was something which they should be committed to, however, realistically it did not work like that. In common with Anthony too, Jon had understood the use of research as being primarily to do with the research they might do as an organisation which had a role in organisational promotion and marketing, rather than the incorporation of ARBK into improving the effectiveness of their service delivery.

Conclusion

This chapter has used explicit knowledge as the focus for the analysis and explored how internally and externally generated knowledge was used by the case studies. Internally generated knowledge served several purposes in the case studies: it was used to deliver services and it was used to sustain the organisation. It's role in service delivery was a vital aspect of the 121

relationships between worker and person, and also to provide a basis for changing or reconfiguring services. In terms of how it was used to sustain the organisation, this was either in relation to fulfilling contract requirements (such as the staff survey, or audit and monitoring data) or to create knowledge which could be used to market and promote the organisation. Explicit knowledge was mobilised by the case studies in linear and relational ways. Emailing documents, reports, and guidance are examples of linear knowledge mobilisation, and conversations at team meetings, and with colleagues are more relational approaches.

Explicit knowledge that the case studies used that was generated outside of the organisation included websites, news feeds, reports and evaluations of other services and policy and other grey literature, as well as academic research-based knowledge. Academic research-based knowledge did not hold a grander status than other kinds of knowledge, but it was not thought of as irrelevant either. The term "academic research" was commonly understood as being about needs assessment rather than about effective service delivery or knowledge for service redesign. Externally generated explicit knowledge was also mobilised through linear means and had a valuable function in keeping abreast of developments in their fields of work and providing proof of claims the organisation might make when writing reports for external organisations, (such as funders) or creating content for the self-management courses. It was therefore not used in a systematic way, but ad hoc, and was not critically appraised for its rigour and reliability using techniques which might be recognised by academics. Table 7 summarises these findings.

Table 7 Summary of explicit knowledge mobilisation findings

| Kind of knowledge | Purpose and Goals | How used? |
|---|--|---|
| Internally generated explicit knowledge Individual level (Whole life planning documentation) | Service delivery – worker and client, service redesign | Linear – completing forms, emails Relational – conversations between team members |
| Internally generated explicit knowledge Service level (Impact and Evaluation Reports, Audit and Monitoring data) | Fulfilling contract obligations to get paid Market and promote the organisation | Linear - uploaded to the client management system, circulation of reports to external commissioning or funding bodies |
| Internally generated explicit knowledge Organisational level (Staff survey, CCG Report) | Fulfilling contract obligations to get paid Market and promote the organisation Provide evidence to commissioners to ‘argue the case’ for their services | Linear – emailed to Commissioners, uploaded to “dashboard” for CQUIN payments. Relational – discussed at meetings, used to support discussions and negotiations |
| Externally generated explicit knowledge: Grey literature reports and evaluations of other services, Government policies, news feeds. | Keeping up to date on what is happening in the Third Sector. Funding opportunities. | Linear – email updates to team members |
| Externally generated knowledge: Academic Research Based Knowledge | Providing evidence of the effectiveness of services. | Linear – used in reports or self-management courses |

Chapter 8 Tacit Knowledge Use by Carnarveon and Chapter One Wellbeing

This Chapter looks at what was termed "other kinds of knowledge" earlier in the PhD research journey. Since then, other kinds of knowledge are now understood to be tacit knowledge, which incorporates practice wisdom, experiential knowledge, as well as gut feeling or intuition. This Chapter is in two parts: Part One looks at tacit knowledge of staff, and Part Two the tacit knowledge of people with lived experience who come into contact with the case study organisations' services or support.

Part One starts in 8.1.1 with a description of the tacit knowledge of staff who provide front line services, and, in that section, I look at the role of the mental health worker, and the kind of knowledge they need to do their job, and how this knowledge might become known, or display itself. In 8.1.2 I explore the purposes and goals of tacit knowledge use by staff, and how the purpose is to build the clients' individual agency and responsibility for managing their mental health condition. In 8.1.3 the way that tacit knowledge is used, how it is shared and learnt is then analysed. In Part Two, I provide analysis of the tacit knowledge of people with lived experience (8.2.1), how this knowledge is developed (8.2.2), what its purpose is and then how it is mobilised or shared within the organisations (8.2.3). In 8.2.4 I then provide a summary of why tacit knowledge is so important to the work that TSOs do, and how it helps to explain how they use explicit knowledge too.

My background working in the third sector meant that to some extent, I already thought that there might be a tendency to use tacit knowledge to work with people in a mental health context, over research-based knowledge. This prior knowledge meant that I needed to be reflexive in how I approached this topic in the data collection and write up. I had my own experience about the way that TSOs make decisions and the kinds of knowledge they used, from work experience prior to starting my PhD and from doing the previous two studies for the research. Plus, doing the fieldwork was a consuming experience: I attended social and work related events, at times I cried with those I met, and we laughed together too. I skirted the edges of "going native", wherein the researcher loses her sense of perspective entirely and decides she will devote her life to the cause or sell all she owns and move to a remote village in the Andes or in my case, give in and instead of researching knowledge use, become a knowledge mobiliser for third sector organisations.

So to be reflexive in these circumstances, I used writing the fieldnotes and talking with my supervisors about the field work as opportunities to debrief and consider how I was interpreting what I was experiencing. As I wrote up the case study chapters, I also reflected on whether and how my own perspectives and judgements were coming through and spent time reflecting what I was thinking back to the organisations I had studied. During these meetings or emails, I would share aspects of the observations and invite perspectives on what they meant. I had developed open and honest working relationships with both case study organisations by the time I left, and so I felt

confident and trusted their feedback. In doing this, my perspective was open to adjustment from those whom I was studying.

The impact this had on my research and the product that is this chapter, is that I came to understand much more about 'why' tacit knowledge was used than I'd anticipated I would. I had wondered if, as had been reflected in earlier work for the PhD, as well as informal conversations with colleagues, that the preference for tacit knowledge was some kind of almost lazy lack of understanding of the value of academic research-based knowledge. What I learnt though was that this was not the point at all: tacit knowledge of recovery, based on organisational and individual values, puts the person at the centre of their recovery, and becomes the lens through which all other knowledge is judged. The question of "what works" becomes "what works for you."

8.1. Part One – the tacit knowledge of staff

8.1.1 Knowledge of all kinds

Understanding staff tacit knowledge through understanding the knowledge needed to work in mental health

I saw tacit knowledge most often as the "know-how" of providing care to people who experience mental health issues. My interest was in the knowledge needed by staff to do their job: the practical wisdom which they learnt on to do the work. To understand the tacit knowledge needed to do the job, I start this section by providing a closer look at the kind of work that these mental health workers did and then go on to discussing what knowledge is therefore needed to work in a mental health TSO.

For both organisations, the role of the mental health workers was to do with facilitating individual recovery. This was achieved differently: at Phoenix, it was to do with learning about your mental health issues so that you would be in a better position to manage them, and this learning occurred through the self-management courses, *and* through belonging and connecting to the community of others at Phoenix. At Carnarveon, the role of the mental health workers in facilitating mental health recovery was more focussed on getting people into employment, volunteering, or indeed even just to get them out of the house, encapsulated in the terminology of helping them with "moving forward". Moving forward was the short-hand that staff used to describe the outcome of their efforts: they were there to help people who came looking for their services move forward towards recovery and living the life they want to live. If they enabled someone to do this, they had succeeded. What moving forward looked like was different for each person that came for help, but the workers seemed to have an understanding of whether or not the person was moving forward, and therefore what constituted the outcome of having moved forward. At both organisations, relapse in someone's mental health, or returning to using their services, or mainstream healthcare services was not necessarily seen as moving *backwards* though: it was felt amongst staff that relapse was a part of recovery and in that, there was an opportunity for learning which would strengthen the person and fortify them to move forward again.

Staff and peer trainers needed explicit knowledge of what might help someone with their recovery journey, but they also needed tacit knowledge for two important reasons: to work with someone as an individual (to use their experiential knowledge to suggest appropriate approaches for that person to try), and secondly, tacit knowledge also enabled them to know how to apply

such knowledge to the person they were working with, or to the group of learners on a self-management course. This "know-how" was shown in the attitude, approach and behaviours of staff towards their work, and towards each other, and in the following section, I explore how this know-how worked.

Staff and volunteers tended to talk of tacit knowledge in terms of the non-book or formal course-based knowledge they had to enable them to do their job. What they described were values, principles and experiences which shaped their attitude, their approach to the work, the kinds of behaviours they engaged in, how they communicated with others and how they treated colleagues. Staff at Carnarveon called this kind of knowledge the 'X Factor', indicating that it was to some extent intangible, and hard to articulate. However, they had found ways to look for markers of this kind of knowledge. For example, during recruitment processes, they would invite candidates to bring along an object to their interview that encapsulated who they were and use it as a talking point during the process. In this way, Carnarveon managers were able to get an insight into the character of the person, how they thought, what was important to them, and how well they understood the role of a vocational support worker. Alongside this insight into the candidate's character, after the interview staff spent time reflecting on whether or not the candidate was someone that they would personally want to spend time with, and whether that person someone who could motivate them to get out of bed in the morning and attend one of the groups.

This knowledge of how to find someone appropriate was shared amongst more senior staff members who were involved in recruitment. In an interview, one of the workers described this kind of knowledge in the following way:

Say I was going to join the team, what would I need to know?

... understanding of mental health issues.

Do I need a clinical kind of knowledge...?

No. I was taught everything I needed to know. I did an understanding mental health course, NVQ level 3, advice and guidance, suicide awareness courses, and stuff around equality and diversity. But... that's stuff that you're taught. The other bit... actually, going back to my first ever interview for Carnarveon, I turned up, [...] And Sarah, HR manager, said you've got no experience but there's something you have, an X factor. So maybe that's what you need. And I've done interviews here, you are looking, Rachel says it sometimes, would you want that person coming to visit you? Would you want that person to be your support worker to help you? So I always have that in the back of my mind. You could, there's something about people. Don't ask me how I know.... but...

But that's actually one of the things I've been learning more about that there is this sort of tacit, gut knowledge that you can't explain about something....

Do you not think though these days we're told to ignore our guts, and actually it's the best thing we've got? You know when you've done something bad, or its good, because your gut tells you, but society tells you to ignore that.

Part of my interest, there is all the written down work which is important for organisations to use, but I'm really interested in that gut knowledge. How is it that we get a feel for something or a situation...?

But then is that not, err, years of experience and things that have happened to you in your life, or things you've seen, becomes this thing in your brain that goes, I've seen this happen and ... I don't know how to describe it. Maybe we don't have to describe it. Sometimes you don't have to... it's human.

That's a reason why I'm interested in it. Almost in trying to pin it down you sort of lose it... like the thing in the corner of your eye.

But it's always there.... the Force. It surrounds us [laughter].

It's in everything...

Maybe that's what you need to call it, but it's true! And I think Carnarveon has it in abundance, and it's a rare thing.

Interview 080517

Markers of tacit knowledge: attitude and approach when communicating

What the worker was describing here was the essence and intangibility of tacit knowledge; that it is something which is based on the experience of similar circumstances but is hard to pin down. Nevertheless, this kind of knowledge then guided how the staff treated people who used their services. One way I observed this was in how staff spoke to people that called the office to find out more about what was on offer at Carnarveon. As Carnarveon offer a range of different services and projects which people can self-refer to, it was not unusual for people to contact the organisation directly (rather than through a referral from a care coordinator). This meant that throughout the day, the phone would ring in the main office, and normally Molly would answer and take down the person's details and arrange for one of the senior management team (normally Jon or Gina) to call back.

However, on some occasions, people would call the office when in distress or crisis. When this happened, sometimes they would speak to their worker, or Molly would speak to them and then generally pass them directly onto Jon or Gina. As I spent much of my working day in the same office, I got to observe the worker's side of these conversations and to see how they put into practice the experiential knowledge of valuing people in all different kinds of contact.

Cat [project worker] came in, to discuss with Jem [team manager] a client that had said yesterday that she wanted to take her own life. Cat had called the GP to let them know and had asked the GP to call the client today. Cat was wondering how to word the text message to the client to let them know. They talked about finding the right wording, and how difficult it was to get the tone right - to be professional and friendly, but at the same time reassure the client as to what had been done and why. They decided not to say 'Carnarveon is not a crisis service', as that sounded a bit judgy. Fieldnote 180517
Spoke with Jon in his interview about a very long phone call he'd had with a client a few days before. He'd been on the phone for nearly two hours, listening as the client shouted down the phone at him about the problems he'd been having with his social worker; with mental health services and with Carnarveon.

He explained "Ten years ago I wouldn't have been able to. But I've learnt. I've learnt not to take things personally, and now I know that very rarely it's about you, it's about their situation. I did that because it feels like an act of kindness, and the most important attribute any human can have is kindness, I wasn't doing anything else, and at the end, he thanked me for it. I've worked with very very challenging people and got some good results from them out of it. There's stuff you realise, is that the true value in life is the reward you get in life from dedicating yourself to other people. The feeling you get for supporting someone else.... there's an understanding that there's no such thing as true selflessness but the currency of using your energy and skills to help someone else is immensely helpful. It stops you from being spiritually and emotionally dysfunctional. I would look for this; that someone gets this currency; that they get paid twice at the end of the day if they do their job properly."

Fieldnote and Interview, 190517

So even something as simple as how a telephone call was handled showed that there was a deep desire to focus attention and effort on what that person needed at the time they needed it. Jon said that he had learnt how to do this through experience, he had learnt that actually, that person's experience and their journey was not about him and how he felt and that instead, being kind when working with people who are angry and upset was effective in helping them.

Markers of tacit knowledge: value relative to book knowledge

I knew how much staff tacit and experiential knowledge was valued, potentially even above formal learning and knowledge because as I was starting my fieldwork, with both organisations, it became clear to me that being a researcher meant people ascribed particular attributes to me, in terms of what I might think was valuable or important. I knew this because of how people behaved towards me and the things they said to me in the early weeks of the work. Dismissive of the research I was doing: "What use is that?", Angela at Chapter One Wellbeing quipped during the first five minutes of the first meeting I had with her or being quite upfront and defensive about their highest level of qualification "I never

went to University, didn't see the point" from David at Carnarveon. I took these kinds of comments on board as useful reflections of what was or could be thought of as being important and valuable to staff. The following field note talks of one of these experiences during a staff away day with Carnarveon.

The whole group was then split up into smaller groups and asked to participate in a task where there was a case study, and the questions were - how can we help this person?

Our case study concerned Maria, and we later found out it was based on a 'true' story, Maria was on the mental health ward, is from Spain, and wants to get a job. She became unwell shortly after arriving in the UK and doesn't have accommodation. So our small group then discussed what might the needs be (translation, accommodation, money/benefits), and what Carnarveon could do. I think it was at this point that Matt said something about Carnarveon's waiting lists and I snorted or smiled, and he took me a bit to task on that, asking why it was funny, and I said it was because I wouldn't have thought they would have them, and he said 'well, why not?'

The task continued as one can predictably think such things do, with people dropping various options, talking a bit in circles at times, and naming other organisations that could help.

After the task had finished, I thanked the group for what I had learnt, and Matt said, 'but have you?', Later, outside during the lunch break, he approached me and repeated: "hope you have learnt something". I was glad he did because I had felt embarrassed during the task that somehow I had mocked the work they do, and so I parroted back to him what I had understood from the conversation, and then said directly that I was surprised by them having a waiting list, and I was sorry if that had come across wrong, because I'd assumed that wouldn't be the case.

And he replied, "why not?", stating that they only have a finite amount of workers, and so obviously they will accrue people waiting for contact. Adam joined us at this point, and the three of us talked about the 'work' of a Carnarveon employment advisor. And I put that in inverted comma's, because the work isn't just the 'finding people jobs', it's the work of building trust and relationships. Matt told me that it wasn't about having degrees and qualifications, "I don't have a degree".

The conversation moved on, and Adam talked about how they are there to help people develop self-awareness, to 'look within', and how that is a new thing for a lot of people. And they talked about how people can become invested too much in someone's recovery journey that they end up thinking that person's outcome (positive or negative) is somehow theirs, and how unhelpful this can be. We talked about book knowledge, compared to "heart/ heart/ hands" knowledge, in the sense that using your head, following your heart, and working practically (i.e. with your hands) is what people needed, rather than theory and discourse, and there was certainly a preference for this kind of knowledge: not that they discounted book knowledge, but rather there was a need for

understanding of mental health, but the knowledge needed to do the job didn't finish there.

Fieldnote, 200217

The emphasis from both workers was that I did not understand what they did unless I understood that they used other kinds of knowledge to help them: developing connections and building relationships, supporting someone to develop self-awareness, these were all activities which relied on staff attitude and approach to the person. The implication was that this was not something which could be learnt (from explicit knowledge) but was something which you cultivated.

This idea, that the knowledge to do the job was about more than book knowledge, and more akin to attitude, was echoed at Phoenix. Louise, the Centre manager, used her experience of working for the organisation, and previously in mainstream mental health services, along with her values and principles to guide what she did, and how she did it, as well as how the tone and culture of Phoenix were set. In the evaluation of the Phoenix learning community, many of the peer trainers said that when they were unsure what to do in a situation, they imagined they were Louise, and asked themselves what she would do. The peer trainers listened carefully to how she spoke to people, to the words she used and the way she behaved and modelled that in their own interactions with one another and the learners.

I asked Louise about her approach in an interview, and she explained it was based on an understanding that people want to be protected, comforted and held; but that the learning for staff and volunteers is to *help people learn to hold themselves*. What she was modelling to the peer trainers at Phoenix was this

way of working: of facilitating people becoming drivers in their own recovery.

This knowledge was something she had cultivated, and its starting point was recognising the incredible value that people being in control of their own lives brought to their recovery.

In an interview, she provided a long description of her first years working as a nurse, and how, even at that stage, her attitude and approach seemed at odds with how care was provided.

I think it's always been a quality I've had and not always been easy to share, anywhere I've been. When I was a general nurse I remember a lady, I was working on an elderly ward, and the sister was shit, well, probably actually in retrospect a nice person but didn't have the authority to tell staff they were terrible, and I went over to a lady who was crying and they were in handover, so I went over and asked why was she crying, and she said because she only went ten minutes ago and they'll shout at me. And I was like, well come on. And she said no, you need two nurses and so I said if I do a bit and you do a bit then we can do this. and she said what do you mean, and I said you push yourself up with a stick, I'll take one arm, and we'll manage. And I wonder whether some of that is like, you know, being able to see it's not right to treat people like that, to make them ashamed. But it's always stayed with me, because she was able to do it for herself, she was motivated with enough support.

She went on to say

One of the things I'm more aware of being here [at Phoenix], is the need that shows up I guess for human connection. Most people who come to courses, I guess most people who work here, understand that need for connection to another person, and some of that connection is through shared experience, some of it through humour, but the community needs to be brought together. My therapist said to me 'what are you doing there?' and I said creating a community where people come together, where there is not a "them and us", there is just an "us together", to get a greater sense of our wellbeing, actually being warm and welcoming, to shout out and be friendly. And so much of that is lost now. But it's amazing how the simplest things like welcoming people, valuing people, celebrating their success, applauding the smallest things people manage to do. That's it.

Louise Interview 141016

What Louise was describing here was a way of approaching the work of being a mental health worker that took a stance that the person coming for support was human and that therefore the knowledge needed to help them was again, human kindness, connection, empathy and being real in that relationship. As described earlier, others that worked at Phoenix took their cue from this, and so the culture of the community was created, on a strong values base that "people matter".

So both organisations took their cue on how to work with someone from considering (consciously or unconsciously) the ethos of their organisation: being "values-led" was important to both organisations and this was manifest in the way that some staff approached their work. These values were not articulated when staff were discussing how they knew how to do their jobs, but I started to draw together ways of working common to both organisations: a focus on being kind to those attending their services, or part of their community, and to each other and secondly, that people really matter; how they feel, what they think are vitally important. In this way, when considering what to do, or how to do it, staff and peer trainers at Chapter One Wellbeing and vocational workers at Carnarveon referred back to these values and considered the next step in light of the knowledge that people matter and should be in control.

However, not all staff upheld these cornerstone values in the same way, and so not all staff had the required know-how to do the job. Within Chapter One Wellbeing, there was variation in how the knowledge of the importance of people influenced the approach, partly because the organisation was in the process of merger, and so was bringing two distinctive organisational cultures together. The vocational support workers from the employment side of Chapter

Chapter One Wellbeing were used to talking about "clients", whereas the nursing staff at the hospital were fonder of 'patient' or 'service user'. However, at Phoenix, where I spent the majority of my fieldwork time with Chapter One Wellbeing, they were simply referred to as people. In each part of that organisation then, the way they spoke about and acted towards and behaved around their people varied too: from the clothes they wore to work, to the food they ate to the language they used.

The tacit knowledge which they need to be a mental health worker is to do with supporting people to develop their own self-awareness and agency which will then support them being in control of their recovery. This kind of tacit knowledge is understood to be related to their attitude and approach and how that guides their behaviour. This was shown in how they communicated with people with lived experience, as well as with each other. It was also understood to be something which could not necessarily be learnt from a book, but was based on experience and treating people as equals.

8.1.2 Purpose and goals of staff tacit knowledge

The know how to work in mental health

One purpose of tacit knowledge in service delivery was to cultivate ways of working that were embedded in a deep commitment to the value and importance of other human beings, and of the people they worked with being in control of their own lives because this led to recovery. If the staff job was to support people towards recovery through various means – finding a job, attending courses, learning to self-manage, developing coping strategies for "bad days", running self-management courses and so on, then they needed tacit experiential knowledge of mental health and recovery to do this. This is

because it enabled them to know how to do what they needed to do: it was the skills and ways of working. Louise said that the skill of being a worker is in saying to the person 'well done, *you've* done it, *you've* taken responsibility', rather than placing themselves, as the worker, in the centre of someone's recovery. She said this was important because the goal of the work is to ensure the person has hope and learns that they are capable of self-management, rather than thinking that the only way to be safe is if someone else (the worker) is in control.

At Carnarveon, I heard on several occasions that the purpose of using this kind of knowledge was about helping people to feel better, more confident about themselves, in the knowledge that this would lead into achieving targets and service level outcomes. "If you look after the people, the targets will take care of themselves" was how this was conceptualised by a couple of people. I saw this in how primacy was given to what the person themselves wanted: during the shadowing with Penelope from Chapter 7, it was clear that she did not have an 'agenda' as such during the meeting: of course she was there to provide a service, but the way she approached this was all to do with finding ways to put Adam in control of what would happen.

So part of the work for staff was not only using their own knowledge and experience of what works to help someone, but also recognising and then supporting their clients to develop their knowledge too. During my time with both organisations, I was told that some of the people who came to them had little experience of using their own knowledge of 'what works', and for some of those people, even being given the option of deciding for themselves what they wanted to do was novel. This way of working, of focussing on what the person

wanted and tailoring support to meet their needs as best as they were able was a principle approach used by both organisations. How they tailored support varied, because what their services provided differed, but the aim was the same: to enable a person to achieve better mental health through whatever non-clinical means possible; through building individual agency and responsibility for managing their mental health.

The Organisational Culture

Experiential knowledge was not just used to determine how to work with people on a one to one basis; it also formed the basis of the culture of the two organisations. At Carnarveon it was reflected in the way staff related to each other: I heard on many occasions during the fieldwork that the senior management team were available and approachable for staff throughout the day, to be on hand to offer support, or a listening ear when staff were experiencing difficulties. These difficulties did not have to be solely related to work: personal problems, marital issues, difficulties with kids at school, there was nothing which happened in the lives of staff that they could not bring to a colleague or a manager to ask for support on. I even experienced this myself: mid-way through the fieldwork at Carnarveon, I was having a "bad day", but had still got up and made the 80-mile journey to the case study site. I was not feeling my best, was feeling anxious about the PhD, and about an ongoing problem with someone back at the University. Maybe I had a metaphorical cloud over myself, but a casual 'how are you' over a cup of coffee with the Chief Executive that morning unravelled into a forty-minute conversation about how stressed and tired I was, and how exhausting I was finding "life": this was met with genuine compassion as we talked through what had been happening.

I saw this caring approach again when Em, the training manager, moved from one service to another; she had to change rooms, moving approximately 20 foot from one end of the building to the other, yet she was given sincere leaving cards and 'welcome to your new home' cards by her colleagues from both services. At the staff away day, when I first arrived, I was ushered into a small training room on the first floor to sign a card by Penelope: they had bought the senior management team a present and a card each in recognition of the great work the team had been doing during the uncertain funding days. When the gifts and cards were handed over just after lunch, the SMT looked embarrassed but genuinely touched that the staff had taken the time to let them know how valuable they were. This kind of care and attention which staff took to look after each other was a strong cultural element to the organisation and again was based on a knowledge that if you look out for people, and treat them kindly, then performance measures and doing the job takes care of itself.

As the two organisations merged into Chapter One Wellbeing, I found that the organisational culture of staff on the health and social care side became more prominent at the Organisational Development Groups and was used at times to correct and model the way of working which was wanted by the Chief Executive. This example taken from field notes on an Organisational Development Group meeting is one example of how this happened.

Sara discussed organisational culture at the ODG today. We were all in the large training room on the third floor of the head office in the city. It was a long morning, and we were sitting round tables, but engaging in a whole room conversation about what organisational culture meant.

The CCT senior staff became quite animated at this point. Frances reminded Sara of the work which they'd done previously on developing staff culture at CCT. Sarah talked about the work they had done to embed recovery as a core value and the work they had done on the ladder of change and communication. She said that Sara had run a year of sessions with staff at CCT to look at all these things to develop the culture, they had spent time questioning everything

they did, stripping away skills and looking at personal qualities and attitudes. Sarah said she still had the laminated handouts they developed together if anyone wanted to see them and then said: "remember 'above and below the line' conversations?" The Health and Social Care staff that had been around longest smiled and nodded. She went on to explain that it was how as a staff team they decided and agreed what is and isn't permissible, and that if someone says something 'below the line' you can ask them about it: how it emphasised their core values about what they all felt was ok, what they stood for as an organisation, and what they wouldn't stand for.

Amanda from the employment side of the organisation cut across, saying that sounded like it would be a very useful way of bringing up poor performance in supervision. She was corrected though as Louise chipped in and said it wasn't about that, it was about recognising that if someone is saying things which are 'mean' it might be because they're struggling with something, and so the need is to ask them if they're ok, and talk to them and find out, and 'below the line' is a way to do that which is non-threatening. So saying that a colleague was talking 'below the line' was an indicator that maybe they're not ok, and they need support, not discipline.

Fieldnote 251016

There were two purposes of tacit and experiential knowledge then in the case study organisations: they helped staff to know how to work with people, and they helped staff know how to work with each other.

8.1.3 How staff tacit knowledge is mobilised

Tacit knowledge was mobilised through different socialisation processes in the two case studies. Some of these socialisation processes were intentional, or formal parts of becoming a staff member (such as the induction), and some were informal and happened through the day to day work of the team. The purpose of this section is to describe these formal and informal processes of tacit knowledge mobilisation. The formal processes of socialisation included training opportunities: self-management courses, peer trainer induction, staff induction and through shadowing more experienced members of staff. The informal processes included "general hanging out", team meetings, "corridor" or office conversations, social occasions, understanding the dress code, and food.

Formal or intentional processes of tacit knowledge socialisation.

Induction and Training opportunities

Chapter One Wellbeing ran a range of different services, all offering help and support for people at different stages of their recovery journeys. The focus of my fieldwork at Phoenix was an attempt to understand the culture there, and to see how the tacit knowledge of the staff was shared and transferred, to understand how people became part of the community and were drafted into the craft of knowing how to be a peer trainer. To do this, I attended a series of induction sessions on a Friday morning, which everyone had to do to become peer trainers. The purpose of the induction sessions was to introduce a group of potential peer trainers to the way of working at Phoenix over the course of four 3-hour training sessions. Before I attended these sessions, I did not have much of an idea about what the courses would contain, and so approached them very much as any other new person.

We met in one of the ground floor training rooms, there were 9 of us there, sitting on comfy sofas, or on the floor. In the middle of the room, on the coffee table, was an assortment of stationary and a large Tupperware box of biscuits. There was a kitchen off the room opposite the training room, and earlier that morning we had milled around making cups of tea and chatting. This had been followed by cigarettes outside in the garden, but now they were extinguished, and we were all in the main training room together, ready and eager to begin.

Louise and Tilly stood and sat adjacent to a projector screen, laptop and projector, and explained the purpose of the induction as being to introduce new staff and volunteers to Phoenix and to talk about things like professional boundaries, safeguarding and communications. The session started with some

group warm-up exercises to introduce ourselves to each other, and then we settled in to listen and watch the PowerPoint. However this was frequently interrupted with interactive exercises, pieces of paper to write thoughts on, or questionnaires to fill in. The discussion on professional boundaries was opened by Louise reading out a question, and each of us filling in our answers on our own sheet; once we'd been through the whole questionnaire, we then discussed, as a group, the answers we had given. Although a few people in the room had been coming to Phoenix for a while, there were new people there like me, and we were encouraged to talk and to give our views and explain our answers too. Louise and Tilly used anecdotes as examples to illustrate the topic, and we were invited to participate and speak up or ask questions whenever we wanted. The PowerPoints were a mix of different styles, and looked quite "home-made"; initially, this was off-putting and did not feel very professional, or well thought out. It did, however, lend the induction session a friendly feel, as the informal nature seemed to take away the threat or tedium that Induction Courses could inspire.

There were frequent breaks during the three-hour session; people went outside to smoke, or off on their mobiles to make calls, or into the kitchen to get cups of tea. The atmosphere was friendly and relaxed, and conversation ranged from pygmy hedgehogs to managing anxiety symptoms. There was a lot of laughter during the session too, and it felt like people were making connections with each other quite readily. The induction did not explicitly discuss issues like terminology and language, but through observing how Louise and Tilly treated the peer trainers, and the words they used (such as calling those that used the services "people or learners" not patients or talking about "lived or living experience", rather than illness) it became clear that there was a strong value of

equality: those that were there learning to be peer trainers were valuable as equal partners in the work at Phoenix, and the people who would be coming along to the self-management courses were equals, or peers, not clients, service users or patients. This was readily accepted by the group, who were themselves people with lived experience of mental distress. After completing the four induction sessions, people were then permitted to start peer training: they would work together with a more experienced trainer on a course, and then co-deliver it, continuing the socialisation processes of learning through shadowing and doing.

Shadowing

At Carnarveon shadowing was used to provide new staff with an approach of how to do the job; the roles were varied and inconsistent, sometimes straightforward office and admin work, other times much more about "giving someone energy" so they could look after themselves. Therefore, there was not one "right" way of doing the role of the worker; everyone I spoke with felt that it was very much up to the individual to find their own way of doing the job; but there was a keen sense that there was a "wrong" way of doing the job. I heard about workers who did not last long with the organisation because they did not understand or 'get' how to do their role: staff explained that their focus was always on helping the person to do what the person wanted to do to be well, and so staff who did not do that, or who thought they knew better did not gel with the organisation or stay very long. In an interview, I asked about whether the right way of doing the job could be learnt. Jon replied that it could, but that it relied on their being a pre-existing aptitude to be person and recovery centred. As many of their staff had been volunteers previously, and therefore by default

people who experienced mental health problems, then I wondered whether for some this lent itself to knowing how to do the job and he agreed.

I shadowed a couple of workers during the fieldwork there and observed how they enacted their role. When I shadowed Paula, one of the other Vocational Workers at Carnarveon, and she explained her role as facilitator to David at our meeting in a local supermarket café he looked a bit confused. She elaborated "I'm here to help you to move forward with your life, in whatever way makes sense to you. So what do you want to do?" Like Adam at the GP surgery, David seemed confused that the service was there to do what he wanted, rather than him doing what the service wanted. He'd spent the previous twenty minutes explaining why it was that he was not at work anymore, the problems with his health, justifying his need for the service. Paula listened patiently to this, nodding, and going "uhuh", so when she posed him this question he seemed to be surprised that he was not being told what to do or told off. She started to take him through the whole life plan, like the one Penelope had used with Adam and used it to continually bring the focus back to him and what he wanted. After the meeting, I asked Paula about her approach and why she worked in that way with him. She looked at me a bit blankly, with a furrowed brow as if I was a being dim or obtuse, and said "Because it works. I'm not there to judge him, I'm there to help him. And the best way I can do that is by helping him to decide what he wants to do". It was the same refrain I had heard throughout my fieldwork at both organisations: what works is what works for the person, they are the arbiter and judge of whether or not something is effective, not the worker.

Informal or less intentional processes of tacit knowledge mobilisation

Aside from learning opportunities and shadowing, there were informal processes through which people learnt tacit knowledge from others. Impromptu meetings or discussions, often held in the kitchen, or outside whilst having a cup of tea and a smoke, were all opportunities for sharing knowledge about how to do the job. Standing around out the back at Phoenix one lunchtime, by the picnic bench in the garden, Tilly was telling of how concerned she was about one of the learners that had been along to a course that morning. Louise kindly leant in towards her and started brushing imaginary fluff off her shoulders, saying with a smile "all we do is create the opportunity, so let's get that weight of responsibility off your shoulders." Tilly smiled and replied that yes, she knew that was the case, but that sometimes it was hard. Louise countered by repeating what she had said in our interview, that this was the job though: to help people learn to hold themselves.

Even seemingly simple issues, like the dress code of staff, or what they ate were open to being influenced by tacit knowledge. At the head office of Chapter One Wellbeing, the dress code was significantly more corporate than at Phoenix. The majority of workers there had come from the employment service, who spoke of the people they worked with as "clients", and who saw their main boss as their funder DWP, (the Department for Work and Pensions), rather than Sara, the Chief Executive Officer.

Due to this perception by some staff that the people coming were clients, and they were advisors and gatekeepers to the resources of the organisation for that person, then they dressed to reflect an interpretation of professionalism which was more akin to working in a bank than working with people who are

experiencing social exclusion. The divide between what people who came for help dressed like, and those who worked there was very distinctive in the employment services. However, in the health and social care services, there was little distinction: staff and peer trainers did not 'dress down', their clothes were well kept, clean, and they looked neat and tidy. But the difference was that their clothes did not try to convey a sense of authority and power; they dressed to be comfortable and to blend in.

I talked about this to Sara one day, about dress codes, explaining that the two sides of the organisation were like looking in the front and then the back of a Next Catalogue (a British high street shop catalogue), where at the front of the book are the smart business-women clothes, and at the back are the 'weekend' clothes. Sara smiled and said she had noticed it too. When I asked Chloe about it, she said that she had definitely changed what she wore when she visited the health and social care services of the organisation; saying it felt uncomfortable to be wearing such smart clothes when you are with people who maybe cannot afford them.

Food was another informal or less intentional context for tacit knowledge sharing. Larchmont, the hospital run by Chapter One Wellbeing, was based in a large house, formerly a guest house, then a residential care home. Just inside the main entrance there was a glass sliding window, which looked into an office, and on the right, there was informal 'office' or waiting room seating, and doors leading into the main house. The staff and many patients were clustered in three rooms along the back of the building: the kitchen, the office and a sort of in-between room, which held lockers, staff notice boards, and two sofas. There were bedrooms upstairs, and a garden area at the back of the

house. Staff or residents cook the meals for the whole house, and staff are included: they cook and eat the same food, from the same plates and using the same cutlery as the people living there. I had never seen such a thing as in my experience of inpatient wards as well as residential care services, that just never happened; sometimes because the food was so unpalatable and sometimes because of not wanting to share cutlery or plates. Louise mentioned an experience they had at a GP surgery when they had gone to a staff meeting to talk about the work at Phoenix and after there was lunch, but the lunch was clearly designated for practice staff and "others" (i.e. the peer trainers from Phoenix). She said it made her quite cross but was also a reminder that there was still a long way to go to conquer the sense of "us and them" in mental health care.

Social occasions too provided another opportunity to understand how tacit knowledge was mobilised. I had not been with Carnarveon very long when it was announced there would be a leaving lunch for a member of staff, and I was invited along. On the day of the lunch, I folded myself into the back of Jon's Audi TT, Penelope got in the passenger seat and we set off to cross the county and got to the pub just as others were arriving too. Inside, the member of staff was already waiting at the bar, and so I quickly introduced myself and wished them well. I'd not met them before because as Jon had explained in the car on the way over that this member of staff had actually been on sick leave for a considerable amount of time, and this 'leaving do' was actually the culmination of a long HR process of helping them to leave the organisation, but to achieve it on good terms. In my prior experience when I was a Charity Trustee, finding ways to respectfully help someone who is long term sick to leave was difficult, and in fact had almost led to an employment tribunal! But here we were, sitting

and laughing together with this person, who if she was angry or upset about leaving, definitely was not showing it.

What these instances of informal or less intentional tacit knowledge sharing demonstrated was a radical stance against creating or perpetuating in-groups and outgroups. The knowledge being shared was that people mattered, and what they thought and felt matters, and that actually everybody was in the in-group, and no one was left out. I spoke to Anthony the director of the health and social care services at Chapter One Wellbeing about this in an interview, and he said that it “wasn't really radical, it was just treating people as people”. Louise echoed this when she quipped, on more than one occasion to the point where it almost became the strap line for Phoenix Learning Community, that when the lunatics take over the asylum, there is no asylum.

8.2. Part Two – The tacit knowledge of people with lived experience

When I started this research, the interest was in ‘how do third sector organisations use research and other kinds of knowledge in their work?’ Since then, I have been able to unpack what this ‘other knowledge’ might be (tacit knowledge) and have looked at it in terms of the staff who work in these organisations, and the know how needed to do their jobs. But while I was on fieldwork, I learnt that there was knowledge which people with lived experience had of how to do recovery, and I wanted to learn and now write about that kind of knowledge because it appeared to me a fundamental outcome of what the organisations were trying to achieve.

However, it is not directly related to the original research question of the knowledge mobilisation activities of third sector organisations; rather it is about their clients, and the kinds of knowledge they use, and how, and for what purposes. I was unsure whether or not to include this section in the write up at all until I realised that its relevance was to explain why throughout this research journey, explicit and research-based knowledge was insufficient for third sector organisations that focus on supporting mental health recovery.

Whilst doing the fieldwork with the two organisations, I came to understand that the self-management courses which both ran were foundational to achieving their organisational purposes of supporting recovery. However, these courses were not simply about learning explicit knowledge about mental health, and diagnoses and treatments and so on, but were also about learner's cultivating tacit knowledge of recovery. If the formal content of the self-management courses was explicit, the know-how of doing or being in recovery was tacit, something which was learnt in similar ways to how staff learnt how to do their job: through socialisation processes, the culture and language, but specifically through trying out different activities that can support recovery so as to work out what will work for the person in question.

In this section, I describe the tacit knowledge of people with lived experience of mental health problems, what the purpose and goals of that knowledge are, and how it was mobilised in the two case studies. In the first section (8.2.1), I define what tacit knowledge of lived experience is, by accounting for the experience of mental ill health given by peer trainers and staff members that I met, and from that go on to describe therefore what kind of tacit knowledge is needed to recover. The analysis of how such knowledge is cultivated and mobilised by

people with lived experience, and within the two case studies is in 8.2.2. My analysis of the purpose and goals of tacit knowledge for people with lived experience is in 8.2.3. People have many kinds of tacit knowledge which they use in their day to day lives, so the focus here is specifically on the tacit knowledge needed to self-manage, and to work towards recovery. The section concludes in 8.2.4 in explaining how tacit knowledge of people with lived experience helps to understand and explain why explicit and research-based knowledge is insufficient for TSOs, and why developing the tacit knowledge of clients is so important.

8.2.1 Tacit knowledge of people with lived experience

In the same way that the earlier part of this chapter started by explaining what tacit knowledge is needed to be a member of staff in the two organisations, this chapter begins with a description of what tacit knowledge is needed by people who are part of these organisations, to help them with their recovery. To begin with, I write about what it is like to live with a mental health diagnosis, and then I draw a contrast between how people were before being part of the organisations and how they were once involved and included. When describing their experiences of mental ill health before attending, I learnt that living with a mental health problem was a socially isolating experience, I heard stories of loss: of relationships, identity, jobs and opportunities. Some that I spoke to described experiences of bewilderment, of not knowing what was happening to them and of hopelessness, of being told that there was nothing more that could be done for them by mainstream mental health care. Following contact with the two organisations, their stories were more about what they had learnt about themselves and how they had learnt and developed knowledge not only of their issue or diagnosis but also of how to manage it more successfully.

What kind of knowledge is needed for recovery?

What this indicates is that the knowledge needed to manage mental health by people with lived experience is not simply explicit knowledge of their condition, or medication, or treatment, but also knowing how to tailor and adapt explicit knowledge to their own experiences. Explicit knowledge was useful in giving ideas as to what might help, but it was the tacit knowledge of how to 'do' recovery that was necessary to tailor such knowledge to their own circumstances, to discover or uncover "what works for me".

What I heard and what I saw on fieldwork was that explicit knowledge, which included research-based knowledge, was a starting point; it provided the framework for some of the courses which they ran, but what was different was that the focus of such sessions was on the individual learners and how they might tailor and adapt what was being shared for their own purposes and recovery. The intention then was to develop tacit knowledge of how to manage your mental health more positively. This kind of knowledge included things like knowing you are not alone; knowing that you can do things; knowing that your experience is valuable and matters; knowing that there is hope that life can be different.

In the next section, I describe the self-management courses that I attended at Carnarveon, to demonstrate this emphasis on tailoring and the way that tacit knowledge was developed and mobilised, and in the section after I use findings from the evaluation at Phoenix to describe the processes which took place to enculturate people to learning how to do recovery.

8.2.2 How is lived experience tacit knowledge discovered and mobilised?

Self-management courses

Following conversations with Em, the trainer, about how the self-management courses were set up, I was intrigued to see what the courses were like experientially. We'd discussed how to justify my presence in the sessions over a conversation and a few phone-calls the previous week and agreed that because they have previously had people observing sessions (as part of her teaching assessment), then it should not be too hard to explain why I was there, and so I sent her an adapted paragraph from the project information sheet which I had prepared for staff, and she adapted it again and sent it out with the course info, inviting people to get in touch if they were uncomfortable with me being there. All the learners were happy with me attending, and so I booked onto the course.

After the course, I interviewed Em. I was interested in understanding the pedagogy of the courses, and how she had decided what kind of knowledge to use. During this interview, Em explained to me the purpose of the self-management courses and her approach.

The biggest thing I say I always start by saying that I'm here to present some information and some might work and some might not, but that's ok because we're unique and human and I can't tell you what you should do, but I can say here are some suggestions and again I think that's how we can work at Carnarveon which is different to traditional mental health services, which is we've got this service, how can you fit in, rather than how we do it which is these are your needs, how can we help?

Interview 180517

What this shows is that the focus is on the individual learner: supporting them to find their own path and encouraging them to take responsibility for themselves.

The teaching approach that Em described was responsive to those in the room,

and in this way, the courses had two functions: to give information but to provide space for people to also direct the learning.

My lesson plan is flexible, so if I go I'm seeing something here, let's explore it, then it helps learners to feel they're being listened to, rather than ploughing on. That makes people feel valued too.

Interview 180517

This second function was important because it validated the learners own perspectives and experiences. However, Em went on to describe that the courses were not simply about people being 'heard' but were also a context within which the learner was encouraged to move forward.

Getting people their voice, they feel valued, and really my job is to go on this journey with them, take them through these suggestions and ideas, and then at the end saying and now you run with what you choose, and you think. When you think about it, and you go to your GP, you do what you're told, but here we give choice and people can take control. Here at Carnarveon we gently nudge people to step beyond their familiarity zone, it can feel safe, what we do at Carnarveon is nudge people out, and to be there to give them support and so I think that's really important.

Interview 180517

During my observation of the courses, I had seen this validation of experience and the encouragement to adapt and adopt different approaches, to try things out and see what worked.

With the 'housekeeping' out the way, Em then explained about the courses. She said that this was an opportunity for learners to discover what works for them. She said that theory was good, in terms of 'these things theoretically are good things, or they work', but to do what works for you. She said the workshops were interlinked and explained that they are based on bringing together knowledge from people who'd done the courses before, as well as the group today. Em said she listens to what learners have to say about the courses, what other ideas or resources they bring, then she goes away and researches those ideas, and brings them in for testing. She added that she has dyslexia and said that there were spelling mistakes in the workbook, but that she has purposefully kept them in there as a reminder that being imperfect is ok. She encouraged us to take the tools in the workbook, and think to ourselves - what does this mean for me? What do I think of it? How do I view it? The emphasis was certainly on making it person-centred and fit for what the learners wanted it to be.

Fieldnote 23 March 2017

Em used explicit knowledge as the basis for the courses, but continually invited input from the learners, as well as sharing with the group what previous learners

had said and done, what others had found helpful and so on. Through sharing these examples it was as if she was demonstrating empathy with everyone in the room, as well as offering different ways of approaching self-management (using her tacit knowledge to tailor and adapt explicit knowledge to the learners). I did not get a sense that there was only one way to Build Assertiveness correctly, but instead, I left feeling clearer about different techniques I could try to improve my overall level of assertiveness in my relationships. I had not felt like I was patronised or lectured at all during the day. I saw Em continually refer everything in the workbook back to the group, asking what they thought of it, whether these were things they had tried, what they might do with this new knowledge. What this showed me was that the approach to teaching and learning on the self-management courses was first off about encouraging people to think for themselves, and to use the courses as a context to do that.

Socialisation into the Phoenix Learning Community

At Phoenix, the intention was to create a recovery learning community, and because of this, for some, the contact they had was more prolonged and extended beyond attending courses to joining groups and becoming part of the team. In this context, tacit knowledge was mobilised through socialisation processes as well as formal learning. I learnt that tacit knowledge was mobilised through seeing others do activities and thinking to yourself 'I could do that'. This was called 'The Power of Me Too' by some of the peer trainers. In the Evaluation which I carried out for Phoenix, they spoke to me about what this meant to them, and about the culture at Phoenix, and how they learnt from

others and were socialised into the learning community. The following paragraphs are adapted from the Evaluation for the purposes of this chapter.

Peer Trainers talked about a non-judgemental approach, that everyone has a part to play, and that their knowledge of their mental health is crucial and central to the work. Contrasting the approach elsewhere, one Peer Trainer commented that:

Phoenix was like totally different, and they just like, the emphasis was more on self-management, whereas other places its more on "we know how you should get better, you will do as we want you to do" [...], they see your diagnosis, "this is the way you will get better", not "you need to find your own way, we'll give you the tools and the resources are within you", it's like "you will follow our directives".

Interview ID03 22/11/2016

References were made about how some Peer Trainers had used the way that the paid workers supported them to support their fellow Peer Trainers or people coming along to the courses or the cafes, which demonstrates that the culture of Phoenix, set by the paid workers, may have been "caught" by the Peer Trainers and is then transmitted onto those that come to Phoenix for support. In an exchange with one Peer Trainer, they explained that the support they passed onto someone else was based directly on a conversation they'd had with one of the paid workers.

I guess this is the Louise influence [laughter] because I've heard her say in the past let people do what they need to do at that point. Um, and I guess she said when she was in [residential service], she had people who would just say in bed all day, and she'd be like yeah, ok, stay in bed, but give yourself a point where you say ok I've been in bed for three days now I've got to get up and go and I guess at the back of my mind that twitched, so I thought, I'll say that to her I'll give that to her.

Interview ID01 22/11/2016

When I asked her why she thought that approach would work, she said

I guess it's because you're not forcing them to do something they don't want to do. If they want to do that, you do that and there's no point saying no you should go for a walk or go down the shop and get some shopping or go out with your husband and take the dog, if you don't want

to do it you're not going to do it and you'll sit at home feeling guilty you've not done it. So if you feel that you want to stay in bed and that's the best you can succeed at that day, then why not? At least that's the impression I get anyway and that's what I picked up from Louise and I must admit I admire her from that, she doesn't mess around she comes straight out and says it, and it's true.

Interview ID01 22/11/2016

What this shows is that the overall approach to supporting people is meeting them where they are at and that this approach is contagious; set out by the Community Manager but adopted and adapted by the Peer Trainers. The culture of the organisation becomes a space within which people learn and understand the "model of care" of the organisation. They pick up and taken on board the qualities and characteristics of those around them and behave and model those to others.

During the fieldwork, I spent time observing the day to day interactions between staff and clients and these observations started to build a picture that the other kind of tacit knowledge held by TSOs comes from the lived experience of mental health problems. The people who came to the services and self-management courses spoke openly about how far they had come, and an important aspect of that was learning what several at Phoenix called, "The Power of Me Too". I first came across this phrase during a cigarette break outside the main centre in the third week of fieldwork. I'd be coming to Phoenix every Friday for a while and was getting to know people. We were standing around outside, in the warm sun, having a quick break during the peer trainers induction session that I'd joined. I was talking to Louise and asking what you needed to know to run the self-management courses. She replied that at the most basic level, peer trainers (people with lived experience, on their own recovery journey), give new participants hope that life can be different. New

participants hear about the experiences of those in the room, what has worked for them, what has not been successful. They see the person training, and being listened to, and heard and taken seriously. And they realise that those they are with understand their experience: they might not have had the same experience, but here, they are understood. This is the Power of Me Too, and it is transformational, as the knowledge that there is hope and that life can improve settles in for someone, they begin to connect to others and to see themselves capable of recovery.

I was intrigued by this concept, and later in the fieldwork, I saw it at work. Maureen had been agoraphobic when she was first introduced to Phoenix. Initially, one of the paid staff members went around to her house and met with her, explained what Phoenix was all about, and encouraged her to come along. Going to meet with her, and then taking her out of the house, to walking to the bus stop, to catching a bus together to Phoenix, the worker slowly helped her overcome her initial agoraphobia. Maureen joined the same induction course as me, and a couple of months later had booked a holiday abroad. She went on this holiday and when she came back, she told me that none of this would have been possible for her if she had not seen how others at Phoenix had managed to do the impossible too.

8.2.3 The purpose and goals of lived experience tacit knowledge use

I understood that there were two uses for lived experience tacit knowledge; a practical purpose, in terms of enabling the person to learn what works for them, and also in developing and using their tacit knowledge, people develop personal agency and responsibility. They reported their self-esteem improved, and their ability to know what they need to be well. In this way, tacit knowledge

development and use work as a mechanism for recovery. People with lived experience developed the skill and knowledge of how to apply what they learnt on the courses and through contact with the organisations, and in doing so, learnt that they are 'ok', that what they say matters, that connection matters: that you have value, and that the thing which caused you so much suffering is something which entitles and qualifies you for all these opportunities.

8.2.4 The importance of lived experience tacit knowledge in explaining knowledge use by TSOs

The emphasis on people with lived experience developing their own knowledge of what works for them is relevant to understanding knowledge use by TSOs because it helps to explain why in the earlier studies, there were comments on how service user views and wishes were not considered in the pilot survey, and should have been, and also the focus elsewhere on the primacy of the service user in what TSOs do and are all about. The earlier part of this chapter discussed the underlying values of staff from the two case study organisations being 'people matter', and 'be kind'. These then translate into putting the experiences, needs and wishes of the person ahead of anything. In doing this, the focus switches from 'what does the evidence tell us to tell people to do' to 'these are some options which have been found to be effective, but what do you think? Would these work for you? Don't worry if they don't.'

In this way then, research-based knowledge can only ever be supplementary to the person discovering for themselves 'what works for me'. Therefore, the kind of knowledge which TSOs need to do their work with people with lived experience of mental health problems is about how to help them unlock their knowledge of what will work for me. Which brings us back to the earlier part of

this chapter and the discussion about staff tacit knowledge on the know-how needed to facilitate and support the journey that people go on to find out 'what works for me'.

Conclusion

In this chapter, tacit knowledge has been explored from two perspectives: tacit knowledge of staff and tacit knowledge of people with lived experience. Tacit knowledge of the staff was understood in terms of the attitude and approach taken when communicating with clients and colleagues; being kind, supportive, friendly and in terms of being a necessary knowledge needed to do the job.

The purpose of staff tacit knowledge was to enable them to do their job which was to support people on a recovery journey to move forward. Book knowledge was insufficient to help staff know how to do this, and so they learnt the tacit knowledge of how-to through formal and informal routes.

Tacit knowledge of people with lived experience was conceptualised as the knowledge needed to adapt and tailor explicit knowledge so that they could progress their recovery. It was learnt through self-management courses, in terms of being encouraged to 'have a go' at different ways of thinking through how to approach wellness, and it was also learnt through the culture of the organisation, of thinking about how others might behave in certain circumstances and modelling that to others. Seeing how other peer trainers and clients had progressed on their recovery journey was incredibly powerful in transmitting the idea that your views, needs and wishes matter and that this tacit knowledge is critical to your recovery journey.

The upshot of this is to understand that because of the huge importance of know-how (both how to do the job, and how to do recovery) then explicit knowledge, including research-based knowledge can be thought of as a tool, but it is not the answer to the question of what supports recovery. Instead, what really support recovery is developing personal agency and learning how to evaluate knowledge by asking “does this work for me?” Recovery is supported through people recognising that their views and experiences matter, and in doing this, they acquire a lens through which all other kinds of knowledge are judged: does it work *for me*?

In the next chapter, I return to the programme theories from Chapter 5, and using the ethnographic findings offer refinements to these theories, answer some questions, and also propose some new one

Chapter 9 Knowledge mobilisation and the third sector: a discussion

In this Chapter, I present the programme theories and additional questions from Chapter 5 and then revise them in light of the ethnographic fieldwork and present a series of refined programme theories which help to explain what kinds of knowledge TSOs use (9.1) why they use knowledge (9.2) and how (9.3). Within each of those sections, I also use my analysis to reflect on what it means for wider debates about knowledge mobilisation and third sector organisations as healthcare providers. In 9.4 I demonstrate how the ethnography fitted within the realist methodology, comparing and contrasting with others who have adopted this approach, and in 9.5 I discuss what the findings on tacit knowledge mean for third sector organisations providing healthcare services and participating in the commissioning process; and also discussing how these results may be transferable to other organisations or sectors working in these kinds of settings.

9.1 Knowledge of All Kinds

What different kinds of knowledge do third sector organisations use?

The Third Sector Organisations I studied seemed to use different kinds of knowledge depending on the different tasks they are undertaking. The different kinds of knowledge include explicit knowledge (which can take the form of reports, research and evaluation, or audit and monitoring data), as well as tacit or experiential knowledge (which takes the form of attitudes and approaches to do the job). The staff have knowledge and skills on how to do their work (know-how) derived from the experience of working with their client group, and from their own experiences of

working in mental health services, or from having mental health problems themselves.

Where does this knowledge come from?

Explicit knowledge is created by the organisation, to meet organisational goals, and is also drawn from sources outside the organisation, such as websites, RSS feeds, conferences and through peers and networks. Staff tacit knowledge is developed through formal and informal processes but is also based on prior experience and their personal attitude and approach to doing the work. The tacit knowledge of people with mental health issues comes from their own experience but may have to be drawn out through the skill of the worker, to enable the person to develop their knowledge of 'what works for me'.

Why do TSOs seem to prefer to use client/user experience and knowledge?

In the context of their everyday work with people who have lived experience of mental health issues, staff that work in the TSOs I studied seem to prefer to use client or user experiential knowledge because, in their experience, it is effective. This effectiveness is judged in two ways: congruence with the individual where they are at in their journey; and the emphasis on the value and importance of taking personal responsibility and developing agency which is activated through the process of staff focusing on what the person thinks and knows. But this preference does not necessarily mean that other kinds of knowledge are dismissed as being at "a different level" and therefore too high minded, or remote from lived experience, just that for staff in these third sector organisations, the ethos of being user-centred drives all that they do: it is the lens through which they see their work, and so the knowledge that clients possess is central to conducting their business. Other kinds of knowledge, such as research-based knowledge is used only in the context of proving something to external agencies about the effectiveness of the organisation,

or in the context of the person's recovery. To put it another way, if research based knowledge proposed a course of action which the person with lived experience thinks is incongruent with what they want to try, then the staff member might encourage them to consider the research-based course of action, but will only offer that, not compel them to do it: the question of determining 'what works' is answered with 'what works for you?'.

In terms of organisational development and functioning, however, there was not a distinct preference for using user knowledge: use of user feedback was under-developed in both organisations (whether that knowledge was explicit in the form of course evaluations, or tacit i.e. when people disengaged from the support offered); and so knowledge for shaping the organisation came mostly from explicit knowledge, drawn from internal impact and evaluation work, from audit and monitoring work, and from knowledge generated outside the organisation. However, again, explicit knowledge from outside the organisation was not necessarily academic research-based knowledge. However, ARBK was privileged with being 'proof' and useful for funding applications or reports to external bodies, but it was not routinely used to direct organisational management or development.

How are different kinds of knowledge integrated?

In terms of integrating different kinds of knowledge, staff used their tacit knowledge of how to do the job, alongside explicit knowledge most obviously in the self-management courses, where explicit knowledge on self-management (from websites, books) was shared but was tempered or tailored based on the needs of the group. I found little evidence of strategic attempts to integrate tacit knowledge (whether service user or staff based) with explicit knowledge when it came to look at

what the organisation did as a whole. Explicit knowledge was always tempered with tacit knowledge (which was often contextual and concerned tailoring the knowledge to the particular situation or individual), but this process did not appear to be overt or self-conscious.

Even so, within the self-management courses, the starting point was always 'what works for you', and this in itself was an invitation to learners to integrate the explicit knowledge with their own-know how. Indeed, the case studies clarify this question: it is not necessarily a case of integration of different kinds of knowledge in a conscious way, rather it is about understanding that this is the objective of the organisations: to support recovery through providing evidence-based and non-evidence-based tools, guidance and support which the individual then incorporates, or not into their own recovery plans.

Gabbay and Le May (Gabbay, 2011), in their 8 year ethnographic study into implementation and use of guidelines in primary care practice, developed the concept of Mindlines to help explain the ways in which different kinds of knowledge are integrated by individuals in healthcare settings. In their study, they observed how clinicians made decisions and what evidence or knowledge was used to inform them. They learnt that clinicians have a sophisticated way of integrating many different kinds of knowledge (tacit, experiential, explicit e.g. clinical guidelines), and bringing them to bear in the present conversation (whether that is with a patient, or with colleagues). Known as 'Mindlines', these are developed through experience and refined through acquiring tacit knowledge from colleagues; and part of what mediated this acquisition was organisational ethos: that is, the values of the general practice. In describing how Mindlines are developed, and so how different kinds of

knowledge are integrated, Gabbay and Le May call this a melange of knowledge, developed through experience, plastic and open to change through further integration and experience of new or different knowledges. Gabbay and Le May's work applies at the individual, patient consultation level, in terms of the basis on which clinicians make decisions, but their work also goes on to discuss and describe how collective Mindlines are developed at a practice, organisational level.

The processes of knowledge integration observed at the case studies echo Gabbay and Le May's findings. At Chapter One Wellbeing and Carnarveon, staff also developed Mindlines to guide how they worked with people, indeed it could be argued that the question 'what works for you?' is an invitation for the person themselves to develop their own Mindlines to support their recovery. The way that such Mindlines were developed by staff at the case studies were similar: through discussion and conversation, sharing different kinds of knowledge with each other, and organisational culture and values shaping how knowledge is integrated. In common with Gabbay and Le May, my study also found it difficult to explain precisely "how" different kinds of knowledges are integrated: the concept of a melange is probably as clear as any explanation.

In 9.2, there is analysis and discussion of transforming what counts as knowledge, however, here it is pertinent to explore how one form of knowledge may be transformed into another (i.e. tacit to explicit, or explicit to tacit). Nonaka's work on the tacit knowledge of organisations, the Knowledge-Creating Company (Nonaka, 1995), drew out different processes which were claimed to be part of a cycle of 'knowledge creation', whereby knowledge of one kind is transformed into another. They called this the SECI (Socialisation, Externalisation, Combination,

Internalisation) model of knowledge conversion. Tacit knowledge is socialised into explicit knowledge in organisations; explicit knowledge is combined with other explicit knowledge, explicit knowledge becomes tacit through a process of internalisation, and tacit knowledge is shared through socialisation processes.

In Chapter 8, the discussion of how tacit knowledge is shared also focussed on socialisation as a means for making this happen. In my fieldwork, socialisation was initially drawn out as the process through which (the 'actions and resources') tacit knowledge was mobilised amongst staff, where new staff learnt the 'know-how' of being a mental health worker through shadowing. With reference to Nonaka's work, the self-management courses, with their focus on teaching explicit knowledge of mental health and wellbeing to learners, and in doing so, supporting the development of tacit knowledge was more akin to the "internalisation" of knowledge, where explicit knowledge becomes so well-known as to become embodied and tacit.

When I returned to the case studies to share the findings and discuss with them what they might mean for organisational development, it was clear that the idea of finding ways to capitalise on tacit knowledge more, and to find ways to make it explicit were popular. We discussed how this could happen, and I suggested that getting those who carried the organisational values strongly to write up vignettes of "a normal day at Carnarveon" could be one way to do this, for them to articulate how they work and why (drawing on their tacit knowledge), and in doing so, externalise it and transform it into explicit knowledge.

If research-based knowledge does not take account of client/user tacit and experiential knowledge of what works then it is insufficient to guide action and decision making.

At an individual one-to-one service delivery level, this programme theory was supported in the ethnographic fieldwork. In one to one work, and in the self-management courses the worker might use research-based knowledge but followed this up with experiential knowledge from previous learners or clients, and their own experience (which might be from experiencing mental health issues themselves, or from working with other clients). A key principle as discussed previously is developing the personal agency and responsibility of people who come for help, so it follows then that if research-based knowledge does not take account of user knowledge then it is insufficient to guide action at this level.

The emphasis from staff on supporting people to develop their tacit knowledge of 'what works for me' has parallels with the overall person-centred approach that was evident in both fieldwork sites. The person-centred approach (Rogers, 1951, Rogers, 1967) is often applied in psychotherapy or counselling practice and is focussed on being client-centred, so the client leads the way in the therapeutic sessions. Using 'unconditional positive regard' (to accept the client as being of worth and value as they are, without negative judgement) therapists seek to support their clients to understand and develop self-knowledge so that they may develop authentic lives and live in greater peace with themselves. In this way then, the tacit self-knowledge which learners at the two case studies develop (the 'what works for me') can be seen as corresponding to this kind of person-centred approach.

In the context of healthcare services, person-centred *care* (PCC) has been conceptualised through three principles: seeing the patient as a person; with their

own individual narrative and experience; and working in partnership with them. In this too, there are parallels with the person-centred approach developed by Rogers: development of positive identities, valuing the person, and seeing the 'work' of care as being a partnership (Britten et al., 2017).

In their paper discussing the Gothenburg PCC model, and its implementation amongst healthcare professionals working across 7 different PCC projects, Britten and colleagues indicate some of the inherent challenges and potential conflicts or limitations of a PCC model: balancing the goals of the person against what is realistic or advisable; how to deliver person centred care when the person may not be well enough, or may not be able to, or is unwilling to enter into a 'partnership'; managing a partnership way of working with someone whilst also maintaining a sense of professional distance: as one interviewee put it "... can't be their best friend as you have to do your job" (p.143). Finally, one of the main challenges with implementing PCC is that it is about the personal approach of the staff, and a changed mindset of what their role was in delivering healthcare.

In considering how these challenges or limitations related to the case studies, it is helpful to point out that at Phoenix, and at Carnarveon, the focus was on learning and/or being in community, and not on being in a 'care' setting. The settings were care-ing, but the relationship between learners or people that attended, and volunteers and staff was not primarily about 'caring' for ill people. Instead, the focus was on people as learners, on what they could contribute, and on creating services which were focussed on learning or on creating community. The idea was that as humans are built for connection, then bringing them together in the context of

learning opportunities builds connection, as well as develops skill and the knowledge needed for recovery.

However, even though what was being provided was not care in the traditional sense, the approach used at Carnarveon and at Phoenix could be considered person-centred, especially the emphasis placed on supporting people to develop their tacit knowledge, and to focus on 'what works for me'. With regards to the challenges or limitations of such an approach as identified by Britten and colleagues, there was some evidence of these in the two organisations.

In relation to goal setting, the challenge was conceptualised as people setting unrealistic goals, and how as a worker you needed to maintain a positive partnership relationship with them whilst also making sure they were not setting themselves up for failure. At both organisations, there was a lot of focus on goal-setting, and this was done in hand with capacity building activities to strengthen self-confidence and self-knowledge. At Phoenix, staff and peer trainers used their experiential knowledge to tell stories (The Power of Me Too) that would encourage people to be goal-orientated, and to see recovery as something that was possible to achieve, whilst at the same time acknowledging that recovery was a journey and that people go at different paces. I encountered a lot of clear honesty in conversations between the staff at Phoenix and the peer trainers: setting people up to fail through developing unrealistic goals was certainly not something which happened. Instead, staff worked proactively with people to raise their expectations of what they might achieve, and then break it into steps. This approach again relied on mobilising explicit knowledge (in terms of what options to achieve which goals was available),

as well as encouraging the development of tacit knowledge by the person; developing knowledge of what would help them.

In terms of being person centred when someone was unwell, or otherwise unable to work in partnership with staff, there was a very high degree of tolerance for this, and indeed, their unwellness was seen as an important part of their recovery journey.

During fieldwork at Phoenix, I learnt that 'stepping away' was an important part of the Peer Trainer's lexicon: it meant that when someone was not well enough to deliver training, they were allowed to and sometimes invited by other Peer Trainers or staff to 'step away' from their role for a short while. In doing this, their recovery journey was actually reinforced: recognition of the need to take care of oneself and then doing so was seen as being fundamental to developing skills for recovery. So instead of having to stop coming along to the Centre, they would have responsibilities lifted, and be encouraged to turn up for the pop-up cafes and social times until they felt well enough to resume teaching.

In terms of maintaining a professional distance so as to be capable of objectively delivering care, I saw this interpreted differently between Phoenix and Carnarveon. As stated previously, one of the purposes at both was to provide learning opportunities, and opportunities for personal development, rather than traditional mental health care. At Phoenix there was training on professional boundaries during the induction of new staff: the focus was on everyone deciding for themselves what boundaries they would and would not be comfortable with (e.g. sharing personal mobile number or address), and relating these examples back to broader principles (equality of service delivery; not having favourites; everyone is included; recognition

of power in interpersonal relationships; respective autonomy; taking responsibility for my 'stuff').

I was not there long enough to see how useful such training was in practice, but I did hear that for some people, they had found it difficult to maintain 'healthy' boundaries and this had led to disagreements or fall outs with in one case someone reportedly stepping away from their peer trainer role and Phoenix completely. Developing tacit knowledge of recovery is an intensely personal experience, and it is not difficult to imagine that in supporting someone to do this for themselves, you may find yourself crossing their boundaries, or having your own crossed. The challenge of maintaining professional boundaries is therefore something which I think will continue to be needed at Phoenix; how to be intentional about building community whilst ensuring that people remain 'safe'.

All of this is in contrast to Carnarveon, where the recovery learning was not being conducted in a 'community' setting, and so the boundary between the trainer (Em) and the learners was established during registration for the courses. Em had told me that she worked hard to make sure people felt welcomed and respected, and safe: and for her safety was part of being boundaried; knowing that it was okay to be yourself, and that you would be accepted as you are on the training, but that there were still standards of behaviour (language used, respecting personal space) which mattered so that everyone could have a positive learning experience. Boundaries were discussed at the start of the self-management courses and were also covered during the course content. Learners at Carnarveon courses could make friends with each other, but there was definitely a clear line between them and Em.

In relation to using research-based knowledge in the organisations at a strategic level, this needs unpacking. In the original iteration of this programme theory, "research-based knowledge" meant explicit knowledge derived from research by academics in Universities, published in journals. What the fieldwork has shown is that research-based explicit knowledge also encompasses the research work generated internally by the organisation. The extent to which this kind of research-based knowledge takes account of service user and clients views' varied considerably, but despite this, it was still used in a range of ways. For example, in the impact and audit reports at Chapter One Wellbeing, there was little inclusion of user views, however, in the delivery of self-management courses, service user perspectives were the focus of the courses: to help people uncover what worked for them, from a range of different sources, some of which were explicit (including externally generated research-based knowledge), and some more tacit and experiential.

So, if, at an organisational level context, research-based knowledge, whether produced by external organisations (such as Universities), or by the organisation itself, does or does not consider service user views is not necessarily a cause of it being used or not being used. Such explicit knowledge is used to achieve a range of organisational purposes which do not seem directly linked to service user knowledge. But if the context is the one-to-one relationship with a client, first and foremost, the focus is on the knowledge of the individual, and this then becomes the lens through which other knowledge is sifted and understood.

For Phoenix, and for the vocational workers at Carnarveon, helping someone work out what would work for them was the overriding perspective they took: so it was not

that research based knowledge was insufficient to guide action at a one-to-one level if it did not take account of user views, but rather that the way that staff worked was not to promote research-based knowledge, and what that said was necessary, but to start with what the person needed, and then provide them with options and opportunities, some of which might be based on research-based knowledge. So it is not a sense of it being insufficient: it could be, but research-based knowledge would only work if it made sense in the framing of someone's lived experience:

9.2 Purpose and Goals

If we cite research in our funding negotiations, then funders are more likely to give us money because they recognise we are an effective organisation.

If we cite research in our funding negotiations, then funders are more likely to give us money because using research raises the profile of our organisation and 'gets us on their radar'.

The two programme theories above hold that citing research has causal powers when negotiating funding. From the scoping review and pilot survey, the theory was that research acts a resource which triggers the funder to reason that the organisation is effective (and therefore should be funded), or to reason or recognise that this organisation exists and therefore could be funded. Whether one mechanism is activated over the other depends on whether or not the organisation is in need of having its profile raised or whether there are other influences in the context operating on the decision making of the funder. These programme theories assume that the two mechanisms which release funding are 1) effectiveness and 2) visibility. The programme theories, being based on the scoping review and pilot survey defined 'research' as explicit knowledge, (whether internally produced or externally imported), and so in the fieldwork, the question became what is it about explicit knowledge that has powers to influence commissioners?

The perception by TSOs which the scoping review and pilot survey developed was that Commissioners need proof of effectiveness to make decisions and that if the TSO was able to provide research this would act as the proof needed. What I found was that research (i.e. explicit knowledge, generated by the organisation, such as impact and evaluation reports), has a role in terms of giving the organisations, as Anthony said, "something to wave at the commissioner", and that audit and monitoring evidence plays a role in reassuring the commissioner and is a mechanism for releasing funding. Research based knowledge was also used to 'back up' claims which the organisation wanted to make in funding negotiations, for example, Carnarveon's use of research in their report to the Clinical Commissioning Group.

However, the "something to wave at the commissioner" mechanism is not that the organisations felt that their research or research they cited would be the causal agent *itself*, but rather they thought that it was necessary to have explicit knowledge which could be handed over, as "proof" of what the organisation did and their effectiveness. The response they were hoping to incite in the commissioner was one of satisfaction and reassurance: satisfied that this organisation had produced impact and reassurance that it would again. What I found in the fieldwork was that what happened next, and whether or not the organisation was then funded was not directly related to having explicit knowledge to cite but was a more complex mix of contextual forces at work on the commissioner (such as the current political climate, and quality of relationships). For example, in the case of Carnarveon and the long report they produced for the Clinical Commissioning Group, the senior management team knew that this in itself would not be what would cause the Commissioner to

continue to fund the organisation, because if that were the case, then it would have happened in that way. What they told me was they knew that without that explicit knowledge, it would be difficult for the Commissioner to argue the case for continuing to fund them. They knew this because they knew their Commissioner and the context within which their Commissioner worked. Their experiential knowledge of Commissioning processes enabled them to understand the rules of the Commissioning game and how they needed to play.

This point is echoed in research undertaken to understand how Healthcare Commissioners use research. Based on observation of meetings and interviews, Lesley Wye identified Commissioners as juggling "competing agendas, priorities, power relationships, demands and their own inclinations to make the best decision circumstances allowed"(Wye et al., 2015). In discussing the role then that academic research might play in decision making, the finding was that academic research was not counted highly amongst the sources of evidence which commissioners sought; and instead, a range of problems was identified with it (a-contextual, hard to access, inconclusive and so on).

These points are familiar, as they resonate with what participants in the pilot survey, in particular, found about academic research too. Wye and colleagues found that despite the competing agendas which Commissioners are enmeshed in, stories and conversations were the most effective routes to knowledge mobilisation: stories which created and sustained momentum, and conversations, formal and informal, where colleagues worked out what to do together. In light of this, the idea that TSOs citing research-based evidence could prove anything to commissioners comes into

stark relief: using research to secure funding, in and of itself is insufficient to gain funding: it is also necessary for there to be other mechanisms activated.

The fieldwork indicated that these were at an interpersonal level (the relationship between the commissioner and senior managers/chief executive at the TSO), as well as an infrastructural level (the presence and range of competing pressures operating on the commissioner). Both case studies felt that without explicit knowledge they did not have a hope in getting funding, but they did not think that just because they had research-based knowledge they would get funded.

Having been asked, dutifully Chapter One Wellbeing produced an Evaluation of Phoenix, with the tantalizing potential that this might be the ticket to get it funded. However, it turned out that the kind of evidence provided (qualitative) was not the kind of evidence the Commissioner said they wanted. The feedback from their commissioner was that the Evaluation was "nice", but that what the commissioner really needed were 'hard facts'. So what then do Commissioners want from third sector evidence?

What I think the organisation was experiencing here was something which Carol Weiss termed the tactical uses of research-based knowledge in bureaucratic politics (Weiss, 1979). The point of the request for research in the Phoenix example was not that research was necessarily needed, but rather a game of call my bluff, where a gauntlet was thrown down by the Commissioner to produce something, and when it was produced, it was not quite the right kind of something (knowledge) and so the point at which a decision would be made about funding moved ever more distant. It made me question what the real motivation was for asking for the Evaluation: the

feedback did not indicate it was because the Acute Care Pathway group were interested in the impact Phoenix was having, but rather might have been more to do with the Commissioner using a delaying tactic, not expecting that Chapter One Wellbeing would be able to produce something.

The indication from the Commissioner that what they wanted was 'hard facts' was interpreted by Chapter One Wellbeing as a desire for quantitative data which showed how the service would prevent admissions or reduce GP appointments: something concrete and tangible, so perhaps the Commissioner would have been persuaded to fund based on a strong robust economic evaluation? I am not necessarily convinced this is the case though: in an evaluation and economic evaluation of another third sector organisation's homeless-out-of-hospital service (Charles, 2015), it was demonstrated that investment in the third sector project was effective (in terms of health and social outcomes), as well as cost-effective (in terms of reducing service use at A&E, and reducing length of stay through reducing delayed discharged). This Evaluation report was used by the Chief Executive of the third sector organisation to persuade potential Healthcare bosses to continue funding (the acute hospital where the project was based, and the local Clinical Commissioning Group), but did not result in any further funding due to wider contextual pressures operating on the Commissioner (budget cuts across health and social care).

Transforming what counts as knowledge.

These programme theories are further refined by the comments from the Director of Health Social Care at Chapter One Wellbeing Anthony, the Business and Innovation Manager Chloe and Louise, the Service Manager at Phoenix. When I met with them a few months after the fieldwork had finished to talk about the analysis, when we

discussed the Evaluation and how things were going at Phoenix, they each said that really, where they wanted to be going, was using their knowledge of 'what works' to influence the commissioner into commissioning based on their knowledge. This knowledge of 'what works' was based on their own tacit knowledge from running the service but also on the explicit knowledge from the Phoenix Evaluation.

Whilst this was in line with how the organisation approached their work (user first, user centric), they recognised that this would be a very long road to change on behalf of the Commissioner, and the healthcare system more widely. This is however congruent with the starting point for this work. Department of Health policy was calling for TSOs to be commissioned and to become providers of services and partners in local health and care action because of their 'distinctive knowledge'.

More than a decade on, it seems that there is still a long way to go before this distinctive knowledge is seen as a valid basis for commissioning (an issue picked up later in 9.5 and in 10.2 in the following chapter). Chapter One Wellbeing had sufficient financial reserves to continue to fund Phoenix whilst trying to influence their commissioner about issues to do with outcomes, and what counts as an outcome. However, organisations that do not have financial reserves may not be in any position to try to influence and so would have to bend to the will of the Commissioner more readily, even if they disagreed with the way outcomes were described and measured.

Despite initiatives such as The Compact aiming to develop partnership relations, and the hope that explicit knowledge in the form of research and evaluations would provide a level playing field between Commissioner and TSO, the outlook is

disappointingly normative: TSOs remain as providers, and the interest in working to harness their expertise remains on the Commissioner's terms.

If we cite relationships/connections/partnerships with research producing organisations, such as Universities, then funders are more likely to give us money because these connections show we are research aware, and symbolically demonstrate the good things about our organisation – cost-effective, effective, and intelligent.

This programme theory was partially interrogated during the fieldwork: the Evaluation I conducted for Phoenix was used by the TSO in their conversations with commissioners; and the value which they ascribed to the Evaluation was not necessarily that it showed they were working with someone from a University, but that me being located within a University, and doing a PhD meant that I could be seen as being independent and objective, that the methods I would use would be systematic and rigorous, and so what I found could be relied upon.

However, in common with the earlier discussion about how Commissioners make funding decisions under a range of pressures, and that research-based evidence is only one factor with that decision making, then in this instance, it could be that it was irrelevant whether or not there was a connection between Chapter One Wellbeing and myself, as a PhD student; what matters is still the relationship the organisation has with their Commissioner. I did not interview the commissioner or members of the Acute Care Pathway Group, where the Evaluation was shared to understand their perspective on the work, and potentially that was a missed opportunity. I was however conscious that the focus of my work was on the behaviours of the people that worked in the case studies in relation to knowledge, and not specifically focussed on how knowledge is used and understood by NHS based meetings.

What are the purposes or goals of using other kinds of knowledge?

The purposes and goals of using non-research-based knowledge (i.e. tacit knowledge), were to equip staff with the skills to do their jobs, with the ultimate outcome being that the people who use their services are in control of their recovery.

9.3 Actions and Resources

How do TSOs get knowledge into action? To what extent do the following mechanisms apply to TSOs: dissemination, interaction, social influence, facilitation and incentives and reinforcements? How else is knowledge shared within the organisation?

This domain was concerned with the mechanisms through which knowledge gets into action; in this way, it seems to resonate with a linear approach to understanding knowledge use, one where discrete "packages" of knowledge can be implemented. In the fieldwork, the interest in this domain was much more focused on how different kinds of knowledge may have been mobilised in different ways because of the different kinds of knowledge they were. For example, there was a range of mechanisms used by the organisations to formally and informally get different kinds of knowledge into action. For explicit knowledge, this was largely a linear process: email exchanges, writing and disseminating reports, talks, attending meetings, minutes of meetings and so on. For tacit knowledge, the mechanisms were shadowing, corridor conversations, socialisation and culture. Little use was made of incentives and reinforcements.

To what extent are TSOs free to use their resources for research and research use?

At face value, the wording of this question gives a straightforward answer: the two case study organisations were completely free to use some of their resources for research and research use, and both did. However, the question was intended to interrogate the circumstances within which TSOs make a judgement about whether

to resource research and research use; which in turn is tied in to whether they prioritise research above other organisational functions.

In terms of how free the two case studies actually were to use resources for research and research use, there was a mixed picture: both organisations recognised the value of having dedicated resources for doing research and research use. At Carnarveon, this function was covered by the Quality Working Party, which at the time I was with them was not running. Their context during the fieldwork was that they were in a period of dynamic change, funding was not secure, and so the resource which would have been used for QWP (Jon), was devoted to other activities to promote the organisation, develop partnerships and secure funding. The explanation given by Jon was that conducting internal research and evaluation at that time was like doing topiary in the garden when the roof of the house was leaking. Nevertheless, staff did use knowledge in less overtly resourced ways: Em, the self-management course facilitator was keen to ensure that the content of the courses was as far as possible evidence-based, even if that evidence came from grey literature, and spent time diligently searching for relevant resources.

At Chapter One Wellbeing, using research was given in their strategic plan as one of the foundations for how the organisation would deliver its business strategy. Chloe was responsible for carrying out many of the research-related tasks (Impact Reports, Business and Innovation Updates), however, this was one aspect of a very busy role, and not necessarily something which the organisation was resourcing well. The reasons for this did not become clear to me during the fieldwork, but I suspect it had something to do with the merger.

The findings from the pilot survey interviews indicated that what was at stake here was a balance that needed to be struck between wanting to be evidence-based whilst also not being seen as wasting resources or diverting resources from front line service delivery. I did not find direct evidence of this balance during the fieldwork: both organisations recognised they were privileged compared to others, in terms of their strong capacity and size which meant they had business development managers (Jon and Chloe), however despite this, neither organisation had a clear strategy for research-based knowledge use.

If research is more accessible, then people that work in TSOs will use it because it is convenient to do so.

This programme theory was based on the thinking that one reason why TSOs may not use research-based knowledge is that it is inaccessible (costly to access, hard to find, difficult to apply). Whilst there is some limited support to this, in terms of how it is costly to access, hard to find and difficult to apply, in the two instances with Chapter One Wellbeing when I offered to do some searching and evidence gathering on their behalf, they expressed a mild interest, however when I had produced some findings, they did not then "use" them. There could be a range of reasons for this, but even so, it is difficult to agree that it is a problem of access and convenience that is at the core of why TSOs do and do not use research. Indeed, Em's work on the self-management course showed an ingenious use of the internet to find research-based knowledge for the self-management courses.

What came across more strongly in the fieldwork is that research-based knowledge in particular, and explicit knowledge more generally serves an instrumental purpose in terms of proving and backing up what the organisation is doing, rather than using it to influence and shape what services are provided.

If people that work in TSOs learn research use skills, then they are more likely to use research because they know how to.

In common with the programme theory above, this theory proposes a potential explanation as to why research is or is not used. The idea is that the reason why research-based knowledge is not used is that people do not know how to search for, read, interpret and apply it and that if that were addressed, they would use research. The fieldwork showed that this was the case, in the sense that staff did not have the kind of skills which an academic would recognise as being necessary to use research (critical appraisal skills, search and review skills). However, what the fieldwork did show that a lack of skill was not the most important reason why research-based knowledge might not be used: a stronger reason was that research-based knowledge itself was seen as having particular purposes (such as in funding applications as proof) and that what really matters in terms of knowledge in the context of these mental health TSOs was tacit knowledge of how to do the job, or how to do recovery. If this was the priority, which it was, then research-based knowledge use is not only a matter of skill in terms of how to use it, but also a matter of utility in the sense of how to use academic research-based knowledge to the objective of supporting someone to work out 'what works for me'. In that way then, research skills to Access, Acquire, Assess, and Adapt are secondary to the tacit knowledge of how to be a mental health worker. Polanyi

9.4 Using ethnography within a realist methodology

I used the ethnographic work to refine the programme theories developed earlier in the study. In doing this, I was following a realist methodology (where different kinds of data and information can be used to build and refine different parts of theory (see Pawson, 2006 Chapter 4), in much the same way that one would if conducting a

realist synthesis. In realist synthesis, the evidence that is reviewed and synthesised does not have to be 'realist' in nature: i.e. gathered using a realist approach or methodology, and its utility is judged by how well it enables programme theory building or refining. In the same way, in this research, I did not conduct a strongly realist ethnography, (e.g. using realist interviewing techniques), but rather, being informed by Hammersley's description of subtle realism (Hammersley, 1992, Hammersley, 2007), I used the methods of observation, interviews and documentary analysis to draw out and reproduce an account of how these two organisations used research and other kinds of knowledge in their work. I interpreted Hammersley's subtle realism as a boundary around the claims which I could make about the work, in recognition that all knowledge is partial and fallible, and that what I constructed from observations, or what I was told in interview, or indeed read in papers and other documents from the organisations was and is always open to further dissection and refinement. This is the work of ethnography and is a balancing act between what we can claim to know, whilst also recognising its fallibility. So the use of realism as an underpinning methodology for the ethnography was a suitable fit, because, as summed up by Davies, ethnographic research needs 'an ontology that asserts that there is a social world independent of our knowledge of it and an epistemology that argues that it is knowable' (Davies, 2008a p18)

I did not use 'realist interviewing' (Pawson and Tilley, 1997, Manzano, 2016) because at the time of doing the fieldwork I felt it sat at odds with an ethnographic approach which focusses on the narratives that people tell, and their ways and approaches to framing knowledge mobilisation. In realist interviewing, the interviewee and interviewer do participate in co-producing knowledge, but the focus is very much on the pre-existing theories or ideas which the researcher has that

have led them to the field, and to the individuals for interview, and “using” the interviewer as a witness or informant to support the refinement of those theories. Whilst I agree with Polanyi (1958) that in order to see, you need somewhere to look from (i.e. that there is no such thing as an objective viewpoint), I was keen in the ethnographic work to follow where the fieldwork took me, rather than to impose too strict a framework which needed ‘completing’. So whilst the programme theories supported case selection and provided me with foreshadowed problems from which I could identify individuals to speak to, or documents to read, through a process of reflexivity, I worked towards keeping my ideas and perspectives, and the programme theories bracketed (as far as that is possible) from what I was actually experiencing and seeing and hearing.

So although I did not adopt a realist approach in my data collection, in terms of realist interviewing, or *only* observing that which directly related to my programme theories, upon reviewing the transcripts and fieldnotes during analysis it was clear to me that I was interviewing and observing in a ‘realist way’. That is, my focus was continually on inviting participants into the programme theories I had developed through asking questions which focussed on how, why and in what circumstances they used different kinds of knowledge. In hindsight therefore, the data itself has a realist flavour to it, even if not overtly gathered using the ‘teacher/learner’ approach outlined by Pawson and others.

The approach of using ethnographic methods to test out realist programme theory in ‘real life’ is not new, and my work follows on from others who have used similar processes. Rycroft-Malone and colleagues explored how protocols are used in healthcare, with a view to understanding in what circumstances protocols can be

said to 'work', for whom, how and why (Rycroft-Malone et al., 2010). They first developed programme theory through conducting an evidence review of policy and research, and then used a case study approach, drawing on ethnographic methods, to test out the programme theories in context. They chose a realist approach for the study because of its attention to context. In common with my own reasons, their use of ethnographic methods was motivated by wanting to understand what was happening in practice,

“Pawson and Tilley argue that realistic evaluators should not be pluralists for pluralism's sake, but that methods should be chosen to test the hypotheses/propositions. Given the broad scope of the initial propositions and a desire to capture how standardised care approaches worked in situ, we used a combination of methods, including those from ethnography ...” (p6).

Another study by Bick et al, which evaluated the implementation of a care pathway for normal birth in one English birth centre also used a realist approach and ethnographic methods (Bick et al., 2009). In that study, the reason for using a realist approach was again to understand how context shapes implementation of evidence, and their reason for using ethnographic methods (observation, interviews, documentary review) was to again understand practice in 'real life', so as to “understand the experiences of different stakeholder groups” (p.3)

More recently, the ethnographic methods of observation and interviews were used within a realist evaluation of the English Collaborations for Leadership in Applied Health Research and Care (CLAHRC) (Rycroft-Malone et al., 2013, Rycroft-Malone et al., 2016). CLAHRCs are based on the idea that if we bring research institutions and healthcare organisations closer together, and into partnership, then research-

based knowledge will mobilise. The initial programme theories of the evaluation were informed by the PARiHS conceptual framework (Rycroft-Malone, 2004) and were further built in a process of documentary evidence synthesis and stakeholder engagement, and then case studies were conducted in three different CLAHRC sites in England to test the programme theories. The case study methods included realist interviewing (the ‘teacher/learner’ cycle), observation, and documentary review. In the full report of the study, there was not an explicit justification as to why observation was used as well as interviews and documentary data collection. The team’s intention was to carry out observation of specific meetings (e.g. Board Meetings), and to use the fieldnotes generated to refine Context, Mechanism and Outcome propositions which had been developed and coded from the interview transcripts. The approach I used was much less structured than the approach taken by Rycroft-Malone and colleagues, as the observation I conducted were blocks of days with the organisation, observing the whole day, rather than only observing specific instances (such as meetings). The benefits of taking this approach were that ‘small talk’ that happened in the kitchen or outside during comfort breaks provided clues (e.g. “The Power of Me Too”) to what would become valuable aspects of the research analysis and findings.

In conclusion, ethnography and realism provide a congruent approach, both philosophically and practically, to conducting case study research where the intention is to understand and describe what is happening in a particular social context, and my own work, and the examples cited above, demonstrate that there is flexibility too in how an ethnographic method can be applied in a realist research or evaluation project.

9.5 Tacit Knowledge, the third sector and healthcare commissioning.

In the second chapter of this thesis, I discussed the role of the third sector in healthcare delivery, and the calls for the 'distinctive knowledge' of the third sector to be harnessed, arguing that the third sector is thought to be capable of reaching communities in a way which is obstructed for public services. In light of the findings on how important tacit knowledge is in how TSOs work, it may well be that the distinctive knowledge that TSOs have is not only of the needs of their communities, and the kinds of services which can meet those needs (explicit knowledge), but also, their distinctive knowledge is tacit too: they have the skill and 'know-how' of how to meet these needs.

Tacit knowledge has, then, been largely ignored as a valuable source of distinctive knowledge by commissioners and policy makers. There is a continued discussion (explored further in the following chapter under 10.3.4) on 'what counts as evidence', and how different kinds of knowledge and ways of knowing are important to delivering healthcare services, yet still, the kinds of evidence required by Commissioners, and delivered by TSOs tends towards the explicit, and in particular the quantitative. What this study has shown is that tacit knowledge of staff is also a really important aspect of distinctive knowledge, and that Commissioners would benefit from developing ways to harness this kind of knowledge in their procurement processes. Future research could work with TSOs and Commissioners to develop these kinds of commissioning processes.

In terms of how generalisable the findings on tacit knowledge might be to other settings or sectors, it is likely that there will be resonance and applicability. What this study has shown is that tacit knowledge is less well understood by organisations but

is nevertheless a key source of knowledge that staff drawn upon in their every-day practice.

There are a range of organisations that TSOs call upon to provide them with research and knowledge, such as the 'What Works' Centres, and the Alliance for Useful Evidence. The Alliance published a review of evidence undertaken by researchers at the EPPI Centre at University College London to determine effective approaches to get evidence into practice (Langer, 2016). From this review, they produced a series of mechanisms, which now form the basis of The Alliance's Evidence Masterclass training programme. The focus of this work was on the use of 'explicit' knowledge (whether academic research-based knowledge, or other kinds of codified knowledge), and my study suggests that there would be benefits in also offering workshops that explore how the tacit knowledge of organisations can be harnessed and shared to improve outcomes for people that TSOs work with.

In terms of how generalisable these findings might be to other sectors or organisations, it is already quite well established that tacit knowledge is understood as being an important kind of knowledge, and whilst my study has shown additional examples of how it matters in mental health care third sector knowledge mobilisation, it remains a less well understood aspect of knowledge amongst TSOs, and other kinds of organisations. Future research could explore the findings and programme theories that have been generated through this study in different settings so as to further develop our understanding of tacit knowledge.

Conclusion

In this chapter, I have taken the programme theories developed earlier in the research and refined them using the findings from the ethnographic fieldwork. This has led to a deeper understanding of the different kinds of knowledge that third sector organisations use and why; to a discussion of what counts as knowledge when it comes to commissioning and funding; how efforts to do organisational evaluation for the purposes of securing funding may be useful but can only be a starting point of securing funding, and that developing meaningful relationships with commissioners is also important. The context for understanding knowledge use by TSOs is to understand the values of staff and the purpose of the organisation: both case study organisations focussed on assisting people in working out 'what works for me', and in doing so, all kinds of knowledge are useful, but the key to their use lies in how useful they are for the individual in question, not in their provenance.

The two case studies used a range of mechanisms to capitalise on the different kinds of knowledge they had available: some of these are familiar linear attempts, but for tacit knowledge, the approach was more relational and focussed on the staff and the clients becoming socialised into the organisation and developing tacit know-how for how to do the job, or how to do recovery. The place of academic research-based knowledge in these socialisation processes is that it is a resource, one amongst many, that can support recovery. But this is not a criticism: rather a reflection of the organisational and staff values that what matters most is the person at the centre of the services. This is the key context within which knowledge is used and it shapes how effective different approaches to knowledge use are.

In the next chapter, some of the main findings are discussed in more depth, along with a discussion of the implications for future research in this area.

Chapter 10 Implications for TSOs, Commissioners, Researchers and Research Funders

The final chapter of my thesis concerns the implications of the work to four different groups of people: those that work in and run third sector organisations; those who commission or fund such organisations; those who research such organisations and those who fund research into such organisations. When I started this work, the focus was very much on understanding the knowledge that TSOs possessed and how and why that was such a valuable commodity to commissioners. Chapter 2 stated that there was a two-fold implication of this: a need to understand the epistemological communities of the third sector, and to understand the role and place of research-based explicit knowledge in the everyday practice of TSOs. The purpose of doing this was to then provide understanding about how to increase the utility of research-based knowledge for TSOs and to provide those that commission, research or work with TSOs greater understanding of the distinctive knowledge of these organisations. This chapter brings together the learning from the research to address these questions. Implications for TSOs are discussed in 10.1, Commissioners in 10.2, those that research TSOs in 10.3 and those that fund research into TSOs in 10.4

10.1 Implications for third sector organisations

10.1.1 Phronesis and what it means for the third sector

The implications for third sector organisations arising from my research are: 1) to consider their values, how they are transmitted, and how that might be shaping knowledge use and 2) to reflect on the relative benefits and dis-benefits of using research in what they do and 3) to reflect on the 'place' of the clients they serve in their knowledge creation and mobilisation activity.

In my research, I learnt that the TSOs I studied seemed to use their values as 'rules of thumb' to help them decide what to do with someone in a particular situation. Values are the anchor for how they use knowledge. They hold this in common with other organisations too, and the judicious application of knowledge for the benefit of others is one of the definitions of knowledge which Aristotle wrote about, that he called phronesis (Flyvbjerg, 2006). Phronesis is not a term widely used or understood in the knowledge mobilisation field. References to it tend towards terming it as practical wisdom; so experiential knowledge, sitting in the tacit domain. However, my reading of sources which have discussed phronesis, lead me to consider that it is more than practical wisdom because it is values based. In the original definition, Aristotle talked about it in the context of moral obligations and doing what would support the flourishing of mankind. Knowledge of what to do (episteme) and how to do it (techne) also needs knowledge of whether to do it, or to wait, or to do it in another way (phronesis), which can be a moral or ethical judgement from the individual.

What I found in my research was that to decide the course of action, staff referred not only to their explicit knowledge of what might help, but also to their tacit knowledge of how to help; but this was mixed with a reference to their values, and to their organisational values (which were not necessarily explicit), which I came to understand as 'being kind', and 'people matter'. This meant then that in the application of knowledge for action, values were referred to in order to determine the right course of action. The implication then is that TSOs that are interested in developing the knowledge mobilisation skills of their staff would do well to pay attention to organisational values and how these are developed in staff and shared

amongst staff. I fed this back to one of the case study organisations, and they thought that they would write some short vignettes of values-based working into their staff induction handbook. They were interested in how the ‘culture carriers’ in their organisation, those who best displayed the organisational values, might provide examples from their own experience of how to work with people, how to do the job of a vocational worker, and why to follow one particular approach over another.

This meant that any kind of knowledge, whether explicit (as in written down, codified, found online, in reports, from talks at events, research based and so on) or tacit (the skill of how to do a job, the ‘know-how’ and gut feelings on what to do, drawn from personal experience) was filtered and then used through this value judgement of “what works for you”, rather than “this is what you should do”. It’s a balancing act between what should be done (according to the facts), and what will work for this person, in their context and given their existing knowledge and skills.

Workers and peer trainers, therefore, focus on offering people with lived experience a range of options, based on their knowledge of what has worked for others, as well as from research evidence-based sources, and other sources (websites, self-management courses), but the emphasis is always on helping the person work out what works for them. This takes skill and experience more than it does book based knowledge and learning. But it can be learnt: the culture of the organisations I did fieldwork with was tangible and infectious. New people learn how to do phronesis through socialisation processes: some of these are formal and intentional (such as induction, or shadowing), and others much less formal (such as corridor

conversations at work, social occasions, listening and learning about the language, dress, and culture of their organisation).

Therefore, the implications are to develop the values of staff and to develop staff phronetic ability. Teach staff and volunteers how to implement values in their work. Develop ways to assess this because it is valuable for commissioners to understand and know about this kind of knowledge because it is distinctive (although not necessarily what they might have thought of as distinctive from thinking about TSO knowledge concerning the "people and communities they serve").

10.1.2 Using knowledge in commissioning and funding relationships

The implication for TSOs in terms of commissioning and funding relationships is two-fold: to consider whether the way that research is used to 'prove' the effectiveness of the organisation is justified, and to consider research-based knowledge as one aspect of achieving commissioning or funding outcomes.

In the previous chapter, I discussed how research-based knowledge did not cause commissioners or funders to commission or fund the case studies. In my fieldwork, the case studies used use research-based knowledge to prove claims which they made about their organisation, and in doing so, research-based knowledge is used in an eclectic and at times, un-systematic and un-critical way. With the two examples given in Chapter 7 of where I undertook to discover what research-based knowledge might have to contribute to the issues in question (acupuncture and self-harm; best way to organise multidisciplinary teams), what I found was not readily adopted or really of much interest to Anthony and Louise. This could have been for

a range of reasons (their interest had moved on to other topics, for example), but it did make me consider that the way which they approached research-based knowledge was much the same as staff at Carnarveon: it provides further resources and information which might be useful, but it does not direct activity. I expect they hold this in common with staff in other kinds of organisations, and it is this kind of behaviour which has led to the concept of practice-based evidence in healthcare, where the focus is on trying to develop evidence from what is done, rather than direct what is done based on research-based knowledge.

The implication though is that TSOs might be missing out on valuable knowledge for practice and that they might be over-stating or under-estimating the effectiveness of what they do. Resource constraints on TSOs, and not having dedicated staff, with the right skills for conducting good quality research and evaluation are all potential problems in terms of TSOs developing a culture of knowledge use that includes the variety and range of ways that research-based knowledge can be useful. Only using research-based knowledge to prove something to a funder or commissioner is selling the organisation short, and furthermore, it does not necessarily lead to the anticipated outcome of achieving funding.

The context within which Commissioners make decisions is not only to do with whether an organisation is effective, and whether research-based knowledge can prove that: decisions are made in a complex and messy reality where other factors are at play. The implication then is to build relationships with Commissioners and Funders, and not to rely on impact and evaluation reports as the only mechanism.

10.2 Implications for commissioners

10.2.1 Understanding third sector epistemology

In the second chapter of this thesis, the reason for working with third sector organisations in healthcare service delivery was proposed to be the need to harness their distinctive knowledge of communities and clients to improve health and care outcomes for communities. Commissioners were urged to work in partnership with TSOs to facilitate this, and a range of policy instruments, such as the Compact was established to enable this relationship. The implication for this work was to do so effectively, it is important for Commissioners to understand just what that knowledge is constituted of, and in doing so, to provide them with decision-support for working more productively with TSOs.

Anthony, the Head of Health and Social Care at Chapter One Wellbeing was keen to change the conversation around outcomes, and what was necessary, so that the full plumage of Phoenix could be recognised for what it was: a radical approach to understanding what it is that people who need mental health support need. An approach that centred itself on the needs of the person, and in doing so, that became the lens through which knowledge would be developed. Doing Impact Evaluations, completing Audit and CQUIN requirements were undertaken to facilitate ongoing relations, but the real heart of the matter was on knowledge and power. Anthony was not convinced of following the funding, and was prepared to bide time until such a point that the Commissioner would come around to their perspective.

The implication then for Commissioners might be to be more open to different ways of knowing, and to different kinds of evidence. In the Chapter One Wellbeing, and

specifically the Phoenix example, the cha-cha-cha around what evidence was required hints at an underlying misunderstanding (whether intentional or not) on what counts as knowledge. If Commissioners do wish to harness the knowledge of TSOs, then there needs to be a better way of reaching consensus on what evidence is needed, and what kind of knowledge is permissible, and to whom. This is not to vilify the Commissioner in that instance, but rather for there to be a climb down from insisting that the only kind of knowledge that matters is quantitative and relates to cost-effectiveness. If this research has shown anything it is that there is a rich and diverse culture of evidence in TSOs, and that richness awaits mining by Commissioners. Approaches to doing this include co-production and collaborative working and the implication is to look for ways to achieve this at the interface between Commissioners and TSO providers. At one point, the Compact, and the different policies which placed emphasis on partnership working opened a door to this opportunity which has since closed. Commissioners could consider that it would be in their interests to open that door again and to consider ways to do this.

10.3 Implications for researchers

10.3.1 Methodological approach

In this section I reflect on the methodology used in the research, and what that implies for future research into knowledge mobilisation. My focus is on: phronesis; the domains of knowledge mobilisation; realist approaches and ethnography.

Phronesis

I was unaware of phronesis as a form of knowledge until I was writing up. For me, it seemed to be an excellent fit to explain what it was that I had found: that it was the judgement call which staff made to decide what to do and how. I contacted knowledge mobilisation experts in healthcare research in the UK and further afield to

draw in further knowledge about phronesis and was surprised to learn that it was not well understood or written about. It may have been mentioned in papers, but just in passing, and so the first implication is for it to become as considered as *techne* and *episteme* as part of the knowledge mobilisation lexicon on different kinds of knowledge.

It's relationship to values, and values-based working also requires further working through: I have made claims here that it is the values of staff, and their organisation which guides their application of what knowledge for whom; but as I did not start this research or conduct the fieldwork with that in mind, further effort is required to determine whether or not and how phronesis is related to values and whether it helps to explain how organisations enact their values in how they work.

The domains of knowledge mobilisation

I used the conceptual map developed by Davies et al (2015) because I wanted to have a framework to support the programme theory building and to support case selection. In that sense, the conceptual map provided me with a straightforward and solid framework to do this and so achieved the purpose I had for it. The difficulty came when analysing the ethnographic data and realising that what happened in the field was not always easily reducible to 'purpose and goals', or 'actions and resources'. In their introduction to the conceptual map, Davies et al (2015) said that the intention for the map is to provide a way to "think through" issues in knowledge mobilisation; I wanted to take it a stage further and use it as a framework for my entire thesis, and in doing so, potentially overreached its utility. If I was to conduct this work again, I would develop domains inductively during the fieldwork, using the

language that people used, and then mapped those to the domains to look for similarities and differences. I think that would have taken longer but may have been useful in developing further insight into knowledge mobilisation. It would also have been “truer” to the kind of organisations I was working with: grassroots, person-led. Where the domains were useful was in helping me to get a grasp on the wide and at time unwieldy literature on knowledge mobilisation and then use this to select cases and develop domains for programme theory.

The conceptual map is focused on research-based knowledge, but I have shown how it can be used when considering tacit knowledge. This is important, as there is little known about how tacit knowledge is mobilised and this thesis contributes towards extending the use of the Domains to look at tacit knowledge in more depth. In general, the influence of the models, theories and frameworks, where reported, tended to be at a conceptual rather than at a more practical level, and so I necessarily had to operationalise them to make them usable in practice.

The methodological implications of my work for the conceptual map is to say that yes, it can provide a framework for others to use, but that the overlapping nature of the domains means that its usefulness for data collection and analysis should not be overstated.

Realist approaches

My reflections on how I have used realist approaches in my PhD are many. Even though I have experience of using realist methodology, have written about it and been published, I still found it a challenge at times to see clearly through a realist lens because my research was not testing out a specific intervention or programme

of knowledge mobilisation. One of the difficulties with using realist approaches when you are not doing evaluation of a specific intervention is that much of the simplicity of a realist approach (map the territory of the intervention or programme, gather evidence to form initial candidate programme theories of explanation, test out whether those programme theories are satisfactory, and where they are not) gets lost. Logically, I followed a similar process: scoping review mapped the territory of knowledge mobilisation; however it did not come up with several neat programme theories to test out; so interviews were undertaken which were hoped to lead to a survey (which would have provided a 'pattern of outcomes' that the rest of the research could have explained by reference to contexts and mechanisms).

However, the interviews found that there were two aspects missing from the thinking behind the survey: the knowledge mobilisation work which TSOs already undertook was virtually ignored and the voice and needs of people with lived experience were also lacking. So, I combined these two studies, and using the conceptual domains of KM map, thought a lot about what they might be telling us about knowledge mobilisation in TSOs. Chapter 5 gave an account of that long and testing piece of work to synthesise and then develop programme theory. And at this point, I felt that some of the programme theories were more akin to further research questions, rather than being realist propositional statements (even though 'thinking like a realist') had gone into them.

Ethnography

In the ethnographic case studies, I was interested a lot in Hammersley's subtle realism and how that helped me make sense of the data which I was collecting. But still, I did not use a strongly structured approach to my data collection: I had wanted

to practice being neutral in my fieldwork, and to be open to what came out. I kept the programme theory domains 'in mind' whilst doing the data collection, but they were not the basis or structure that I used every single day I was in the field.

Realists talk about using an iterative approach, developing theory through several cycles of data collection and consolidation. I do not, however, think I achieved this in my research: in fact, what I think this research has achieved is several cycles of theory building; theory testing would likely need a different approach.

10.3.3 Strengths/weaknesses

There is a range of strengths and weaknesses with this research. The strengths are found in the use of an in-depth, case study approach to determining the epistemological communities of TSOs. Linking values to knowledge mobilisation is also a strength. Using the Davies et al (2015) conceptual map as a framework, whilst it had its problems, was also a strength in that it extended that model which was based on a framework of mostly explicit knowledge mobilisation research and tested it out by using it to explore tacit knowledge use (where it also worked well).

The weaknesses: the scoping review may have missed important and relevant studies due to the keyword searching. The pilot of the survey tool was based on a small sample of people that worked in third sector organisations in two counties in England; a wider application may have diversified the findings. The case studies were very similar in many ways which were not apparent at the start of the fieldwork. Choosing a case study who was 'anti-research' or more strongly evidence-based, or one that was more explicitly user-led might have yielded different results. In addition, resource and time constraints meant that the fieldwork was not as long as might be desirable and potentially if fieldwork had commenced nearer the start of the

PhD, rather than half way through, there would be further insights to be gained, and ideas about phronesis and user voice could have been explored further. One of the biggest weaknesses of this research though must be that it did not take a co-production approach. I debated for a while about this and had intended to use a PhD reference group throughout the research to support the development and delivery of the work. I did not achieve this, partly because during the second and third year I suffered very badly with anxiety and depression and was just about capable of conducting the research and partly because I was interested in going in 'blind' to the cases, whilst recognising that this was not entirely possible. I did not want to fall victim to some of the dominant discourses that arise when those who work for and in third sector organisations get together: *it's hard for us, commissioners are out to get us, funders don't understand*. I wanted as far as possible to make my own mind up and let the fieldwork speak to me. However, if I was to do further work in this field, I would be really interested in working with third sector organisations throughout the process of research design, data collection and analysis.

10.3.4 Scientific validity and objectivity: What counts as objective knowledge?

The framing of this research was necessarily exploratory and seeking to describe and explain what does occur. It could be seen as defending an anti-scientific viewpoint, one that rejects the scientific method as being capable of producing generalisable knowledge. I have reflected a lot on this during the research process, and have come to the decision that I agree with philosophers of science, such as Polanyi (Polanyi, 1958), who suggest that in order to look or observe, one needs to be looking from somewhere, and that somewhere is based on different factors which

then influence what is looked at, how, why and in what ways. The findings of my research do indicate that what researchers might recognise as scientific objectivity and validity are absent from the development of the self-management courses for example; after all, Em's best test of whether or not something was effective was very much whether people fed back that it was (either vocational workers, or the learners themselves). But does this mean that in these circumstances that is a problem? Or does it suggest that the way that validity and objectivity are framed and famed is in fact contested in practice?

This is not new territory and indeed different philosophical approaches to the endeavour of producing knowledge for action suggest that a positivist or empiricist approach "know-that" is only one way of understanding the world around us. My research used two other Aristotelean approaches to knowledge: *techne* and *phronesis*, and both do not subject themselves easily to the usual tests of validity and objectivity. But does that mean they are any less valuable or useful? My research would indicate that in fact, without them, empirical knowledge is dead in the water.

As a realist, I too would also hold that whilst there is a mind independent reality, our knowledge of it cannot be objective because we cannot operate from a God's eye view. As a human and a researcher, we bring our own prejudices, experience and interests to the work we do. There is nothing wrong with this either. But it does mean that in reality, there is no such thing as objective or final knowledge of something; there are better or worse explanations, and our ability to objectively state that 'this is it' remains flawed. In the complex, messy realm of knowledge mobilisation processes, we are working within open systems and whilst we might

artificially be able to close them somewhat (through stating what we mean by case), we cannot close them completely. There is always the likelihood that we will uncover some new knowledge which will challenge our current knowledge, and which needs considering.

What my research found was that phronesis is the mechanism through which sense is made of different kinds of knowledge by staff. Phronesis works with the end result in mind of “the flourishing of mankind”. Following this logic, if something based on what might be considered “objectively and scientifically valid” yet does not lead to the flourishing of mankind, then what use is it? The judicious application of knowledge is as important as the knowledge being applied.

10.3.5 Future research

Areas for future research would include testing out these findings in other kinds of TSOs, such as smaller user led organisations, or national organisations. The intention in my work was to look at everyday TSOs, so ones which did not have access to a national research and policy function or team, but ones which did have sufficient size and presence to be commissioned to provide services.

In addition, the surfacing of phronesis as a partner to techne and episteme deserves further attention. Whilst understood as being ‘practical wisdom’, I think it is more than that, and future knowledge mobilisation research with TSOs could explore further how organisational and individual values influence knowledge use and how such values are developed, transmitted and sustained in organisations.

I did not explore with the organisations how their tacit knowledge became explicit in the organisation, and to what purposes this serves. Future research might well investigate this, especially regarding finding ways to capitalise on and show the impact of such knowledge. Methodologically, there is room to further test out how mechanisms of socialisation facilitate knowledge mobilisation.

10.4 Implications for research funders

In the summer of 2018, there was a call for expressions of interest in a large UK National Institute for Health Research grant focused on developing research programmes focused on the Third Sector in healthcare. One of the questions in that call was “How do TSOs use research evidence in designing and implementing services? Research using theories of knowledge mobilisation is required to understand both how TSOs access and use research evidence and other knowledge to inform their activities, and examples of effective practice.”

I felt ambivalent when I learnt of the NIHR call. On the one hand, I was pleased that others were getting interested in a field which has been my focus and passion for the last four years, and the scope covers many of the issues which my work has touched upon. But I was also disappointed and unsurprised as I re-read the whole call, about the way in which the questions were being asked, and the assumptions made:

“The third sector lacks evidence to underpin the different models used to input their expertise to commissioners and other providers”

“There is also a lack of evidence-based guidance on how these TSOs should use research to inform their activities, and for the outcomes and impact for commissioners of these activities.”

They imply a deficit model of research and knowledge use by TSOs and are based on assumptions about what the third sector is like, and how it works. What I think my work implies to researchers and research funders is that in common with other organisations, TSOs may have a culture of evidence use, which for TSOs may be governed by their underlying organisational values and purpose. For the two case studies I studied, the values determined the value and importance of any other kind of knowledge. In this way, they are promoting the cause of the people they work with, putting them at the centre of what they do, and focusing efforts on helping them work out 'what works'.

The funding call signifies an increasing interest in understanding research and knowledge mobilisation by third sector organisations, which I welcome. More research is needed to understand how and why these organisations are effective. My work has focused on understanding what they actually do when it comes to knowledge use. Work that would focus on putting some of these theories into practice by working with TSOs on developing knowledge in practice is necessary. However, the potential danger is that the call makes assumptions: that TSOs find it hard to provide quality evidence about the effectiveness of what they do; that they are not literate when it comes to using research; that they lack sophistication in their evaluation activity and so on. This starting point is in common with the deficit model uncovered in the scoping review and the pilot survey.

A more positive and I suggest a fruitful way of approaching research on third sector healthcare organisations would be to start with an open mind and to develop with third sector organisations research that is of value and useful to them. To approach

the research from a point of humility about what is already ‘known’, and to start from that point, looking and exploring what is, before assuming “researchers know best”.

Conclusion

Undoubtedly, research-based knowledge improves healthcare and medicine and saves lives. It is a professional and moral obligation to provide services that are based on the best possible knowledge of what is effective and cost-effective. In uncovering and focusing on the tacit knowledge of the staff and clients who work for and use Third Sector Organisations, my research is not seeking to dispute the enormous value, contribution and necessity of research-based knowledge to helping us understand how to make healthcare services effective. Instead, my work argues that what is considered knowledge must continue to incorporate different voices and that an empiricist view in health services research is in danger of cutting out these necessary perspectives, leaving our knowledge of ‘what works’ impoverished. If we are to achieve the best outcomes, irrespective of what kind of organisations we might work for, we must listen to all kinds of knowledge and work to understand and incorporate this knowledge in what we do. The risk is that if we do not, we will continue to miss a significant and valuable contribution which not only can improve healthcare services but which also helps us to understand what could be done to increase the relevance and utility of research-based knowledge.

Appendices

Appendix 1 List of models included in the review by Davies et al (2015)

They identified 71 reviews relating to knowledge mobilisation, and from these 71 articles, they identified the main models, theories and frameworks used in knowledge mobilisation work.

The Institute for Healthcare Improvement (IHI) Model for Improvement (Langley 199649).

Plan-Do-Study-Act (PDSA) cycles (Kilo 199850).

Ottawa Model of Research Use (OMRU) (Logan and Graham 199851).

The Promoting Action on Research Implementation in Health Services (PARIHS) Framework (Kitson et al. 199852).

Push, pull, linkage and exchange (Lomas 2000;10 Lavis et al. 200653).

Knowledge Dissemination and Utilisation Framework (Farkas et al. 200354).

Lavis et al.'s framework for knowledge transfer (five questions about the research, four potential audiences)

(Lavis et al. 200355).

Mindlines (Gabbay and le May 2004;56 Gabbay and le May 201157).

The Greenhalgh model for considering the diffusion of innovations in health service organisations (Greenhalgh et al. 200431,58).

The Levin model of research knowledge mobilisation (Levin 200459).

Walter et al.'s three models of research use (Walter et al. 200460).

The Knowledge to Action (KTA) Cycle (Graham et al. 20061).

Collaborative knowledge translation model (Baumbusch et al. 200861).

The Interactive Systems Framework (ISF) for Dissemination and Implementation (Wandersman et al. 200862).

The Knowledge Integration framework (Best et al. 200863).

The three generations framework (Best et al. 2008;63 Best et al. 200964).

The Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 200965).

The Critical Realism and the Arts Research Utilization Model (CRARUM) (Kontos and Poland 200966).

Normalisation Process Theory (May et al. 200967).

Participatory Action Knowledge Translation model (McWilliam et al. 200968).

Ward et al.'s conceptual framework of the knowledge transfer process (Ward et al. 200919).

The Knowledge Exchange Framework (Contandriopoulos et al. 201021).

The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) KTA Framework

(Wilson et al. 201169).

Knowledge translation self-assessment tool for research institutes (SATORI)

(Gholami et al. 201170).

School Improvement Model (EEF71).

Appendix 2 Scoping Review Search Strategy

Identification of Studies

Bibliographic Database Searches (CC)

The bibliographic databases used in this scoping review were selected purposively in relation the studies aim. We also selected these databases because of the content they offer, which is a mixture of peer-reviewed studies, charity reports, grey or hard-to-locate literature, and research reports.

| Database | # |
|---------------------------------------|-------------------|
| HMIC | 284 |
| Social Policy and Practice | 395 |
| CommunityWise | 169 (10 imported) |
| Assia | 661 |
| British Library Social Welfare Portal | 20 |
| Total | 1370 |
| Duplicates Removed | -104 |
| Unique Records to Screen | 1266 |

Database: HMIC

Host: OVID

Data Parameters: 1979 to January 2014

Date Searched: 10/03/2014

| # | Searches | Results |
|----|--|---------|
| 1 | (voluntary or charity or charities or charitable or "third sector" or TSO or "civic sector" or "social sector" or "social enterprise" or Non Government* or NGO or "community based" or "community sector" or "community organisation" or "profit" or "nonprofit" or "not for profit" or "big society" or "civil society" or foundation*).ti,ab. | 13726 |
| 2 | charities/ | 513 |
| 3 | voluntary groups/ or community groups/ or neighbourhood care/ or third sector/ or voluntary organisations/ | 1301 |
| 4 | 1 or 2 or 3 | 14348 |
| 5 | ((us* adj2 evidence) or (role adj2 evidence) or (role adj2 research) or (us* adj2 research)).ti,ab. | 2265 |
| 6 | ((knowledge or research or evidence) adj1 (transfer* or exchange or broker* or practice or mobilisation or translation or translating or generation or utilization or utilisation or implementation or dissemination)).ti,ab. | 858 |
| 7 | ((uptake or "take up" or adoption or adopting or adopted or intergrat*) adj3 (research or evidence or knowledge or science)).ti,ab. | 253 |
| 8 | evidence-based practice/ or evidence-based policy/ | 2487 |
| 9 | Research implementation/ | 222 |
| 10 | decision making/ and (knowledge or evidence or research).ti,ab. | 1723 |
| 11 | "what works".ti,ab. | 243 |

| | | |
|----|--|------|
| 12 | (diffus* adj2 (innovation or research or evidence or knowledge or information)).ti,ab. | 64 |
| 13 | 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 | 6999 |
| 14 | 4 and 13 | 284 |

Database: Social Policy and Practice (SPP)

Host: OVID

Data Parameters: 201401

Date Searched: 10/03/2014

| # | Searches | Results |
|---|--|---------|
| 1 | (voluntary or charity or charities or charitable or "third sector" or TSO or "civic sector" or "social sector" or "social enterprise" or Non Government* or NGO or "community based" or "community sector" or "community organisation" or "profit" or "nonprofit" or "not for profit" or "big society" or "civil society" or foundation*).ti,ab. | 24211 |
| 2 | ((us* adj2 evidence) or (role adj2 evidence) or (role adj2 research) or (us* adj2 research)).ti,ab. | 2659 |
| 3 | ((knowledge or research or evidence) adj1 (transfer* or exchange or broker* or practice or mobilisation or translation or translating or generation or utilization or utilisation or implementation or dissemination)).ti,ab. | 941 |
| 4 | ((uptake or "take up" or adoption or adopting or adopted or intergrat*) adj3 (research or evidence or knowledge or science)).ti,ab. | 264 |
| 5 | "what works".ti,ab. | 1274 |
| 6 | (diffus* adj2 (innovation or research or evidence or knowledge or information)).ti,ab. | 33 |
| 7 | 2 or 3 or 4 or 5 or 6 | 4967 |
| 8 | 1 and 7 | 395 |

Database: CommunityWise

Host: Oxmill

Data Parameters: unknown

Date Searched: 05/03/2014

| # | Searches | Results |
|---|---|---------|
| 1 | Using evidence | 93 |
| 2 | Use of evidence | 34 |
| 3 | Evidence use | 3 |
| 4 | What works and (charity or voluntary or third sector or profit) | 20 |
| 5 | Role of research | 19 |

Database: ASSIA

Host: ProQuest

Data Parameters: (1987 - current)

Date Searched: 10/03/2014

Set#: S1

Searched for: (voluntary or charity or charities or charitable or "third sector" or TSO or "civic sector" or "social sector" or "social enterprise" or Non Government* or NGO or "community based" or "community sector" or "community organisation" or "profit" or "nonprofit" or "not for profit" or "big society" or "civil society" or foundation*)

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 26316*

Set#: S2

Searched for: ((us* N/2 evidence) or (role N/2 evidence) or (role N/2 research) or (us* N/2 research))

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 11194*

Set#: S3

Searched for: ((knowledge or research or evidence) N1 (transfer* or exchange or broker* or practice or mobilisation or translation or translating or generation or utilization or utilisation or implementation or dissemination))

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 7°

Set#: S4

Searched for: ((uptake or "take up" or adoption or adopting or adopted or intergrat*) N3 (research or evidence or knowledge or science))

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 56°

Set#: S5

Searched for: "what works"

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 359°

Set#: S6

Searched for: (diffus* N2 (innovation or research or evidence or knowledge or information))

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 0°

Set#: S7

Searched for: s2 or s3 or s4 or s5 or s6

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 11604*

Set#: S8

Searched for: s1 and s7

Databases: Applied Social Sciences Index and Abstracts (ASSIA)

Results: 661°

* Duplicates are removed from your search but included in your result count.

° Duplicates are removed from your search and from your result count.

Database: British Library Social Welfare Profile

Host: <http://socialwelfare.bl.uk/>

Date Searched: 10/03/2014

| # | Search Terms | Search located/included |
|-----|-----------------------------------|-------------------------|
| 1. | "evidence use" | 5/1 |
| 2. | "using evidence" | 119/6 |
| 3. | "role of evidence" | 20/0 |
| 4. | "research use" | 23/0 |
| 5. | "use of research" | 66/0 |
| 6. | "using research" | 67/1 |
| 7. | "knowledge mobilisation" | 5/3 |
| 8. | "knowledge transfer" | 107/7 |
| 9. | "what works" AND charit* | 9/1 |
| 10. | "what works" AND "third sector" | 0/0 |
| 11. | "what works" AND "not for profit" | 2/0 |

Appendix 3 Scoping Review Data Extraction Sheet

| Reference Author, year, country | Study Aim | Methods Who involved? How involved? | Type of TSO, incl type of services provided | Specific KM/RU strategy (if any) | Findings. E.g. Types of knowledge/evidence/decisions studied What were the barriers to KMB? What facilitated KMB? | Study strengths Study limitations |
|--|--------------|---|--|---|---|--|
| | | | | | | |

www.chsrf.ca / www.fcrrs.ca

IS RESEARCH WORKING FOR YOU?
A SELF-ASSESSMENT TOOL AND DISCUSSION GUIDE FOR
HEALTH SERVICES MANAGEMENT AND POLICY ORGANIZATIONS



Canadian Health Services Research **Foundation**
Fondation canadienne de la recherche sur les services de santé

*...making research work
...pour que la recherche porte ses fruits*

OUR PURPOSE

VISION

Our vision is a strong Canadian healthcare system that is guided by solid, research-based management and policy decisions.

MISSION

To support evidence-based decision-making in the organization, management and delivery of health services through funding research, building capacity and transferring knowledge.

STRATEGY

To establish and foster linkages between decision makers (managers and policymakers) and researchers in the governance of the foundation and in the design and implementation of programs to support research, develop researchers and transfer knowledge.

This document is available on the Canadian Health Services Research Foundation web site www.chsrf.ca.

For more information on the Canadian Health Services Research Foundation, contact the foundation at:

1565 Carling Avenue, Suite 700
Ottawa, Ontario
K1Z 8R1

E-mail: communications@chsrf.ca
Telephone: (613) 728-2238
Fax: (613) 728-3527

Ce document est disponible sur le site Web de la Fondation canadienne de la recherche sur les services de santé www.fcrrs.ca.

Pour obtenir de plus amples renseignements sur la Fondation canadienne de la recherche sur les services de santé, communiquez avec la Fondation :

1565, avenue Carling, bureau 700
Ottawa (Ontario)
K1Z 8R1

Courriel : communications@fcrrs.ca
Téléphone : (613) 728-2238
Télécopieur : (613) 728-3527

IS RESEARCH WORKING FOR YOU?

A SELF-ASSESSMENT TOOL

WHY USE THIS TOOL?

In today's healthcare systems, it is essential for organizations to make the best use of an ever-growing body of research information. Provincial or territorial health ministries, hospitals, professional practices, long-term care organizations, or community health organizations can all gain significant advantages by using research in the right way.

This self-assessment tool from the Canadian Health Services Research Foundation will help you identify how you gather and use research and where there is potential for improvement.

The foundation can assist in your assessment and discussions at any stage. Feel free to contact:

Senior Program Officer, Research Use
Canadian Health Services Research Foundation
1565 Carling Avenue, Suite 700
Ottawa, Ontario K1Z 8R1
Canada
Telephone: (613) 728-2238
Fax: (613) 728-3527
research.use@chrsf.ca

MAKING DECISIONS IN HEALTH SERVICES

Difficult financial, organizational, and resource decisions must be made by those who fund, organize, and set priorities in health services, by those who develop health policies, and by health services providers.

Today's healthcare systems are changing rapidly and decision makers face:

- a complex environment;
- vast quantities of information that are often contradictory and come from many different sources; and
- new demands for accountability.

ABOUT RESEARCH...

Research is one of many sources of information and data used in making decisions.

In particular, *health services research* can help to:

- explain the need for certain decisions;
- show the reasons for choosing one of many competing arguments;
- increase confidence in decisions that are made; and
- help build consensus.

ABOUT SELF-ASSESSMENT...

Using this tool can help your organization determine:

- how research is currently being used;
- where research is located;
- the capacity within your organization to locate and use research;
- ideas for better use of research; and
- next steps your organization should consider.

SUGGESTIONS FOR USING THIS TOOL

Self-assessment will work best if:

- a group of decision makers and interested people in your organization works together on the answers, discussing them as you go along;
- the answers are collated and used for the second half of the tool called **Our Results: A Discussion Guide**; and
- you consider the suggestions in the "What Next?" section to use the results in an effective way.

ABOUT THIS TOOL...

There are four general areas of assessment.

1. **Acquire:** can your organization find and obtain the research findings it needs?
2. **Assess:** can your organization assess research findings to ensure they are reliable, relevant, and applicable to you?
3. **Adapt:** can your organization present the research to decision makers in a useful way?
4. **Apply:** are there skills, structures, processes, and a culture in your organization to promote and use research findings in decision-making?

Since this is an assessment, there are no right or wrong answers.

ABOUT THE RATINGS

The choice of ratings for each question varies, depending on the nature of the question.

In all cases, a rating of "1" means a low capacity or frequency of activity, while a "5" signifies something your organization is well-equipped to do or does often.

PART ONE: ACQUIRE

1.1 ARE WE ABLE TO ACQUIRE RESEARCH?

RATING

1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

| | | | | | |
|---|---|---|---|---|---|
| We have skilled staff for research. | 1 | 2 | 3 | 4 | 5 |
| Our staff has enough time for research. | 1 | 2 | 3 | 4 | 5 |
| Our staff has the incentive to do research (it is used in our decision-making). | 1 | 2 | 3 | 4 | 5 |
| Our staff has the resources to do research. | 1 | 2 | 3 | 4 | 5 |
| We have arrangements with external experts who search for research, monitor research, or do research for us. | 1 | 2 | 3 | 4 | 5 |

1.2 ARE WE LOOKING FOR RESEARCH IN THE RIGHT PLACES?

RATING

1 = Don't do 2 = Do poorly 3 = Do inconsistently 4 = Do with some consistency 5 = Do well

| | | | | | |
|--|---|---|---|---|---|
| We look for research in journals (that is by subscription, Internet, or library access; examples are the <i>Journal of Health Services Research & Policy</i> and <i>Healthcare Quarterly</i>). | 1 | 2 | 3 | 4 | 5 |
| We look for research in non-journal reports (grey literature) by library, Internet access, or direct mailing from organizations such as ministries of health, the <i>Centre for Health Economics & Policy Analysis (CHEPA)</i> , or the <i>Centre for Health Services and Policy Research (CHSPR)</i> . | 1 | 2 | 3 | 4 | 5 |
| We look for research in databases by subscription or Internet access, such as the Canadian Institute for Health Information, the Cochrane Collaboration, and citation indices. | 1 | 2 | 3 | 4 | 5 |
| We look for information on web sites (those that collate and/or evaluate sources) such as <i>Best Evidence</i> or <i>Bandalier</i> . | 1 | 2 | 3 | 4 | 5 |
| We work with researchers through formal and informal networking meetings with our staff. | 1 | 2 | 3 | 4 | 5 |
| We get involved with researchers as a host, decision-maker partner, or sponsor. | 1 | 2 | 3 | 4 | 5 |
| We learn from peers through informal and formal networks to exchange ideas, experiences, and best practices. | 1 | 2 | 3 | 4 | 5 |

PART TWO: ASSESS

2.1 CAN WE TELL IF THE RESEARCH IS VALID AND OF HIGH QUALITY?

RATING

1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

| | | | | | |
|---|---|---|---|---|---|
| Staff in our organization has critical appraisal skills and tools for evaluating the quality of methodology used in research. | 1 | 2 | 3 | 4 | 5 |
| Staff in our organization has the critical appraisal skills to evaluate the reliability of specific research by identifying related evidence and comparing methods and results. | 1 | 2 | 3 | 4 | 5 |
| Our organization has arrangements with external experts who use critical appraisal skills and tools to assess methodology and evidence reliability, and to compare methods and results. | 1 | 2 | 3 | 4 | 5 |

2.2 CAN WE TELL IF THE RESEARCH IS RELEVANT AND APPLICABLE?

RATING

1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

| | | | | | |
|--|---|---|---|---|---|
| Our staff can relate our research to our organization and point out similarities and differences. | 1 | 2 | 3 | 4 | 5 |
| Our organization has arrangements with external experts to identify the relevant similarities and differences between what we do and what the research says. | 1 | 2 | 3 | 4 | 5 |

PART THREE: ADAPT

3.1 CAN WE SUMMARIZE RESULTS IN A USER-FRIENDLY WAY?

RATING

1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

Our organization has enough skilled staff with time, incentives, and resources who use research communication skills to present research results concisely and in accessible language. 1 2 3 4 5

Our organization has enough skilled staff with time, incentives, and resources who use research communication skills to synthesize in one document all relevant research, along with information and analyses from other sources. 1 2 3 4 5

Our organization has enough skilled staff with time, incentives, and resources who use research communication skills to link research results to key issues facing our decision makers. 1 2 3 4 5

Our organization has enough skilled staff with time, incentives, and resources who use research communication skills to provide recommended actions to our decision makers. 1 2 3 4 5

Our organization has arrangements with external experts who use research communication skills to present research results concisely and in accessible language. 1 2 3 4 5

Our organization has arrangements with external experts who use research communication skills to synthesize in one document all relevant research, along with information and analyses from other sources. 1 2 3 4 5

Our organization has arrangements with external experts who use research communication skills to link research results to key issues facing our decision makers. 1 2 3 4 5

Our organization has arrangements with external experts who use research communication skills to provide recommended actions to our decision makers. 1 2 3 4 5

PART FOUR: APPLY

4.1 DO WE LEAD BY EXAMPLE AND SHOW HOW WE VALUE RESEARCH USE?

RATING

1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

Using research is a priority in our organization. 1 2 3 4 5

Our organization has committed resources to ensure research is accessed, adapted, and applied in making decisions. 1 2 3 4 5

Our organization ensures staff is involved in discussions on how research evidence relates to our main goals. 1 2 3 4 5

The management of our organization has clearly communicated our strategy and priorities so that those creating or monitoring research know what is needed in support of our goals. 1 2 3 4 5

We communicate internally in a way that ensures there is information exchanged across the entire organization. 1 2 3 4 5

Our corporate culture values and rewards flexibility, change, and continuous quality improvement with resources to support these values. 1 2 3 4 5

4.2 DO OUR DECISION-MAKING PROCESSES HAVE A PLACE FOR RESEARCH?

| RATING | | | | | |
|---|-----------------------|--------------|--------------------------------|-----------|--------------------|
| | 1 = Strongly disagree | 2 = Disagree | 3 = Neither agree nor disagree | 4 = Agree | 5 = Strongly agree |
| When we make major decisions, we usually allow enough time to identify researchable questions and create/obtain, analyse, and consider research results and other evidence. | 1 | 2 | 3 | 4 | 5 |
| Our management team evaluates the feasibility of each option, including potential impact across the organization as well as on clients, partners, and other stakeholders. | 1 | 2 | 3 | 4 | 5 |
| Decision makers in our organization give formal consideration to any recommendations from staff who have developed or identified high-quality and relevant research. | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders know when and how major decisions will be made. | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders contribute evidence and know how that information will be used. | 1 | 2 | 3 | 4 | 5 |
| Staff who have provided evidence and analysis usually participate in decision-making discussions. | 1 | 2 | 3 | 4 | 5 |
| Relevant on-staff researchers are made part of decision-making discussions. | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders receive feedback on decisions, with a rationale for the decision. | 1 | 2 | 3 | 4 | 5 |
| Staff and appropriate stakeholders are informed of how available evidence influenced the choices that were made in our organization. | 1 | 2 | 3 | 4 | 5 |

OUR RESULTS: A DISCUSSION GUIDE

Based on the self-assessment, our organization should work on the following areas so that we can use research better to make informed decisions that help meet our goals and objectives:

1. Establish research as a priority in our organization (Check one)

We feel research in our organization should have:

- Much higher priority Somewhat lower priority
 Somewhat higher priority Much lower priority
 The same priority

2. Integrate the use of research into the work of people in our organization (Check one)

We feel we need to:

- Integrate research much more often Integrate research slightly less often
 Integrate research slightly more often Integrate research much less often
 Maintain our current level of integrating research

3. Encourage the use of research by our decision makers (Check one)

We feel our decision makers:

- Do not use research at all Use research with some consistency
 Use research poorly Use research well/enough
 Use research inconsistently

4. Increase our capacity for research

(Check all that apply. If you have more than one answer, please rate your needs from 1 to 5, with 1 being the highest priority.)

We need:

- ___ Skilled staff ___ Incentives
 ___ Resources ___ Arrangements with external experts
 ___ Time

5. Acquisition of research

(Check all that apply. If you have more than one answer, please rate your needs from 1 to 5, with 1 being the highest priority.)
We need better access to:

- | | |
|--|---|
| <input type="checkbox"/> ___ Journals | <input type="checkbox"/> ___ Web sites |
| <input type="checkbox"/> ___ Non-journal reports (grey literature) | <input type="checkbox"/> ___ Opportunities to work with researchers |
| <input type="checkbox"/> ___ Databases | <input type="checkbox"/> ___ Learning from peers |

6. Assessment of research

(Check the one that is most appropriate or best describes your situation.)
We need to:

- | | |
|--|---|
| <input type="checkbox"/> Begin to assess and adapt research | <input type="checkbox"/> Adapt and assess research a bit less often |
| <input type="checkbox"/> Assess and adapt research more often | <input type="checkbox"/> Adapt and assess research much less often |
| <input type="checkbox"/> Maintain our current ability to assess and adapt research | |

7. Linking of research results to key issues facing our decision makers

(Check the one that is most appropriate or best describes your situation.)
Our decision makers need to:

- | | |
|---|---|
| <input type="checkbox"/> Begin to consider research in making decisions | <input type="checkbox"/> Consider research a bit less often |
| <input type="checkbox"/> Consider research more often in making decisions | <input type="checkbox"/> Consider research much less often |
| <input type="checkbox"/> Maintain our current frequency of considering research | |

OUR QUESTIONS BASED ON OUR RESULTS

The results of this self-assessment tool will be used by the foundation to assist your organization in better targeting the information and resources you need.

These are sample questions that will fit many situations, but take time to write those specific to your organization based on the self-assessment exercise.

Our organization has the following questions about making research work for us.

1. How do we help our organization understand the importance of research?
2. How do we access skilled staff?
3. How do we access outside assistance with research?
4. What training is available in writing research summaries?
5. What case studies can we cite to emphasize the importance of research?
6. Is research acquisition costly?
7. What if we cannot afford research?

WHAT NEXT?

The Canadian Health Services Research Foundation has a range of resources for managers and policy makers to find and use research. For example, we have an inventory of promising practices that show how other organizations have addressed similar challenges, and we organize workshops where research users can work with their peers to adapt these approaches to their own needs. The foundation also connects health-system managers and policy makers with the research — and the researchers — that can help them address key challenges.

For example, if your organization is interested in partnering on a research project, you may be interested in the foundation's guide on how to be a good research partner (www.chsrf.ca/other_documents/pdf/partner_e.pdf).

Or, if your organization is interested in providing skills to senior managers that enhance their ability to better use research in their daily work, you may be interested in the Executive Training for Research Application (EXTRA) program (www.chsrf.ca/extra/).

There are many other foundation resources that can help, and we can point you to what is available outside the foundation. To initiate a discussion about what you can do, please contact:

Senior Program Officer, Research Use
research.use@chsrf.ca
Tel: (613) 728-2238
Fax: (613) 728-3527



How do third sector organisations use research and other knowledge in their work? Piloting a self-assessment tool

UEMS REC REFERENCE NUMBER: 14/11/060

INFORMATION SHEET FOR INTERVIEW PARTICIPANTS

VERSION NUMBER 2, 10 February 2015

Thank you for your interest in this study. Please read this information sheet carefully before deciding whether or not to participate.

What is the aim of the project?

Third Sector Organisations (TSOs) play an important and expanding role in health and social care provision, with over 35,000 TSOs providing health and social care services in England. Income for TSOs from public sector contracts and grants has increased from £9.1 billion in 2001/2 to £14.2 billion in 2010/11.

However, compared with research into research use by NHS providers, there is very little research into how TSOs use research and other forms of knowledge. In particular, it is not clear what the current baseline of research use is amongst UK TSOs, and what particular issues they face in accessing, assessing, adapting and applying research and other knowledge in their work.

The aim of this pilot project is to adapt an existing self-assessment questionnaire in order to use it with UK based TSOs to find out how they access, assess, adapt and apply research and other knowledge in their work. The original survey tool was developed for Canadian organisations and only focussed on their use of research. I want to adapt it so that it is meaningful and useful for TSOs in the UK and for assessing how they use other types of knowledge – not just research.

Description of participants required

This pilot phase will involve people who work in senior positions in TSO organisations in the South West Peninsula. Participants are required to work for TSOs that provide health and social care services.

What will participants be asked to do?

You will be asked to participate in an interview with me (*Rebecca Hardwick*).

The purpose of the interview is to get your views on the self-assessment tool so that it can be adapted for UK use and to get your views on how to conduct a wider survey of other third sector organisations, using the adapted tool. The interview may be face-to-face or over the telephone, depending on what is most convenient for you.

The interview will be digitally recorded so that notes can be taken afterwards. All information you share will be kept confidential, but will be used to inform the development of the self-assessment tool for use in organisations like yours. If any things you say are used in reports or academic publications, they will be anonymised and not attributable to you individually or your organisation. However it is important for you to know that you or your organisation may

inadvertently be identified if you describe in detail activities which relate to a distinct area of practice or service that you provide.

The interview will not be discussing sensitive issues. However, if you agree to participate, you can stop the interview at any time, refuse to answer any question, or withdraw your data without any disadvantage to you. If you wish to do so, just let Rebecca know.

Time commitment

Interviews will last approximately one hour.

What if participants have any questions?

If you have any questions about our project, either now or in the future, please feel free to contact me:-

Rebecca Hardwick, Associate Research Fellow

r.j.l.hardwick@exeter.ac.uk

01392 727408

Or Professor Rob Anderson, who is supervising this project:-

R.Anderson@exeter.ac.uk

01392 726058

Complaints

If you have any complaints about the way in which this pilot study has been carried out, please contact the Chair of the University of Exeter Medical School Research Ethics Committee:-

Peta Foxall, PhD. Chair, UEMS Research Ethics Committee Email :

P.J.D.Foxall@exeter.ac.uk

**This pilot project has been reviewed and approved by the
University of Exeter Medical School Research Ethics Committee**

How do third sector organisations use research and other knowledge in their work?

UEMS REC REFERENCE NUMBER: 14/11/060

CONSENT FORM FOR PARTICIPANTS

VERSION NUMBER 2, 10 February 2015

I have read the Information Sheet Version Number 2 Dated 10 February 2015 concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that (please circle):

- | | | |
|----|--|----------|
| 1. | my participation in the project is entirely voluntary; | Yes / No |
| 2. | I am free to withdraw from the project at any time without any disadvantage; should I wish to do so I can also request that any recordings and information collected from me are destroyed | Yes / No |
| 3. | the data will be retained in secure storage; | Yes / No |
| 4. | the results of the project may be published and steps will be taken to preserve the anonymity of me and my organisation in such publications. However, I understand that if I discuss services which are unique or highly specialised this may inadvertently reveal the identity of my organisation. I understand that because of this, total anonymity cannot be assured. | Yes / No |

I have discussed this project with my organisation's Chair, and can confirm that as an organisation, we agree to take part in this project.

| | | |
|--|-------------|---------------|
| | | |
| (Printed name of participant address) | (Signature) | (Date) (Email |

| | | |
|------------------------------|-------------|--------|
| | | |
| (Printed name of researcher) | (Signature) | (Date) |

This project has been reviewed and approved by the University of Exeter Medical School Research Ethics Committee



***How do third sector organisations use research and other knowledge in their work?
Organisational Case Study***

UEMS REC REFERENCE NUMBER:

**CONSENT FORM FOR HEADS OF ORGANISATION
VERSION NUMBER 1 03/06/16**

I have read the Heads of Organisation Information Sheet ver 1 dated 03/06/16 concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that (please circle):

1. I have approval from our Governing Committee to give consent for our organisation _____ to participate in this research project. Yes / No
2. I understand that our organisation's participation in the project is entirely voluntary; Yes / No
3. I am free to withdraw our organisation from the project at any time without any disadvantage; should I wish to do so I can also request that any recordings and information collected from our organisation are destroyed Yes / No
4. The data will be retained in secure storage; Yes / No
5. The results of the project may be published and steps will be taken to preserve the anonymity of me and my organisation in such publications. However, I understand that the data collection may include detail of services which are unique or highly specialised this may inadvertently reveal the identity of my organisation. I understand that because of this, total anonymity cannot be assured. Yes / No

.....
(Printed name of participant) (Signature) (Date)
(Organisation)

.....
(Printed name of researcher) (Signature) (Date)

Heads of Organisation Information Sheet ver 1 03/06/16

How do third sector healthcare organisations delivering services on behalf of the NHS use research and other knowledge?

Rebecca Hardwick, PenCLAHRC, University of Exeter

Background

Enabling research to influence the care of NHS patients is an important activity. We know that organisational and individual staff circumstances influence the way that this happens. Third Sector Organisations (TSOs) deliver a growing proportion of care to NHS patients, especially to people with mental health problems. So it is important to know how they use research. But very little is known about this. What research there is suggests TSOs may give greater value to non-research types of knowledge - such as what staff know from their experiences of providing care, or what other similar organisations have learned and shared.

The aim of this study

This research project will investigate how TSOs use research and other knowledge in providing their services in order to tailor efforts to enable them to use knowledge more effectively.

Who am I?

My name is Rebecca Hardwick, and I am in my second year as a PhD student at the Institute for Health Research, University of Exeter Medical School. Before this, I worked for the South West Development Centre, funded by NHS South West to support policy implementation in health and social care, with a particular focus on commissioning and the voluntary sector. I have also worked in the Voluntary Sector, for Mind, the mental health charity, as well as for a mental health self-advocacy project in Devon. I have Chaired a Charity and have been a Trustee.

Why [Organisation name]?

Specific outline of why they are to be a case.

What is ethnographic research?

Ethnographic research has its roots in anthropology and is concerned with understanding the stories, actions and experiences of a culture, society, or organisation. It involves a range of data collection methods (participant observation, interviews and focus groups, documentary analysis) with the intention of building up an understanding of the phenomena of interest. It provides an opportunity for the researcher to understand the organisation 'from within', and in doing so provides valuable explanations on how and why an organisation functions as it does.

What will it entail? What does it mean to be a case study?

The fieldwork will take place over a 5 month period, and will involve me visiting your Premises, attending meetings, interacting and shadowing staff and observing how the organisation uses research and knowledge in its work. My focus is on mental health care, but the research does not require any contact with patients receiving your services.

I anticipate I will be visiting 3 days a week during the 5 month period. As the fieldwork continues, I will be interviewing key members of staff about their experiences, knowledge and views on research and its use in the organisation. I will also be reading your strategies, policy documents and annual reports and the like.

I will need a liaison person at Director level who can be a point of contact for staff or service users that want to talk about the project, as well as agreeing and consenting that the organisation is allowing me to conduct research.

What benefits can you expect?

You can expect to benefit in the following ways: opportunity for learning how the organisation uses research and other kinds of knowledge in its work; opportunity to identify ways to enhance the use of research knowledge; further establishment of relationships between the organisation and PenCLAHRC.

[Ethics, Confidentiality and Anonymity](#)

The study is currently with the University of Exeter Medical School Research Ethics Committee for approval following feedback.

The process of gaining ethical approval includes due consideration for the confidentiality and anonymity of participants and organisation, correct consenting procedures, data protection, protection of participants from risk or harm and support for participants.

The Third Sector is well networked and data collected may identify your organisation by alluding to services or activities that you provide which are specialist or highly identifiable. This means that I cannot guarantee 100% anonymity. However, I will take the following steps: participants will not have their name, or the name of their organisation attributed to their comments in the write up of the findings. Where detailed quotations are used, which may put the anonymity of the organisation or individual at risk, these will be shared with the original interviewee for them to approve prior to publication.

[Contact:](#)

Rebecca Hardwick, PhD Candidate
r.j.l.hardwick@exeter.ac.uk 07795
170458

Prof Ken Stein, Deputy Director,
PenCLAHRC. (Director of Studies)
K.Stein@exeter.ac.uk

[Complaints:](#)

If you have any complaints about the way in which this study has been carried out, please contact the Chair of the University of Exeter Medical School

Research Ethics [Committee](#):-

Ruth Garside , PhD or Rob Anderson, PhD

Co-chairs of the UEMS Research Ethics Committee Email:

uemsethics@exeter.ac.uk



How do third sector organisations use research and other knowledge in their work? Organisational case study

UEMS REC REFERENCE NUMBER: JUN16/B/073)

**INFORMATION SHEET FOR INTERVIEW PARTICIPANTS
VERSION NUMBER 4 20/06/16**

Thank you for your interest in this study. Please read this information sheet carefully before deciding whether or not to participate.

What is the aim of the project?

Enabling research to influence the care of NHS patients is an important activity. We know that organisational and individual staff circumstances influence the way that this happens. Third Sector Organisations (TSOs) deliver a growing proportion of care to NHS patients, especially to people with mental health problems. So it is important to know how they use research. But very little is known about this. What research there is suggests TSOs may give greater value to non-research types of knowledge - such as what staff know from their experiences of providing care, or what other similar organisations have learned and shared.

So the aim of this project is to interview people who work in TSOs to find out more about how they view research in what they do, how they use research, or not, and what other kinds of knowledge informs their work.

Why me?

You have been invited to take part because you work in a third sector organisation that provides healthcare services in the South West.

What will I be asked to do?

You will be asked to participate in an interview with me (Rebecca Hardwick). The purpose of the interview is to ask you a series of questions about research use in your organisation. The interview may be face-to-face or over the telephone, depending on what is most convenient for you. I may also ask you for basic descriptive information about your organisation (e.g. no. of staff, turnover/income, main client groups, key types of care professional used)

The interview will be audio recorded and will be transcribed for analysis. All information you share will be kept confidential. If any things you say are used in reports or academic publications, they will be anonymised and not attributable to you individually or your organisation. However it is important for you to know

that you or your organisation may inadvertently be identified if you describe in detail activities which relate to a distinct area of practice or service that you provide.

The interview will not be discussing sensitive issues. However, if you agree to participate, you can stop the interview at any time, refuse to answer any question, or withdraw your data without any disadvantage to you. If you wish to do so, just let Rebecca know.

Time commitment

Interviews will last between no more than 1 and 1.5 hours.

What if participants have any questions?

If you have any questions about our project, either now or in the future, please feel free to contact me:-

Rebecca Hardwick, Associate Research Fellow
r.j.l.hardwick@exeter.ac.uk
01392 727408

Or Professor Ken Stein, who is supervising this project:-
K.Stein@exeter.ac.uk
01392 726067

Complaints

If you have any complaints about the way in which this study has been carried out, please contact the Chair of the University of Exeter Medical School Research Ethics Committee:-

Ruth Garside, PhD
Co-chairs of the UEMS Research Ethics Committee
Email: uemsethics@exeter.ac.uk

**This project has been reviewed and approved by the
University of Exeter Medical School Research Ethics Committee**

How do third sector organisations use research and other knowledge in their work?

Organisational Case Study

UEMS REC REFERENCE NUMBER: JUN16/B/073

CONSENT FORM FOR PARTICIPANTS

VERSION NUMBER 4 20/06/16

I have read the Information Sheet Version Number 4 **Dated 20/06/16** concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that (please circle):

- | | | |
|----|--|----------|
| 1. | my participation in the project is entirely voluntary; | Yes / No |
| 2. | I am free to withdraw from the project at any time without any disadvantage; should I wish to do so I can also request that any recordings and information collected from be are destroyed | Yes / No |
| 3. | the data will be retained in secure storage; | Yes / No |
| 4. | the results of the project may be published and steps will be taken to preserve the anonymity of me and my organisation in such publications. However, I understand that if I discuss services which are unique or highly specialised this may inadvertently reveal the identity of my organisation. I understand that because of this, total anonymity cannot be assured. | Yes / No |

| | | |
|---|-------------|--------|
| | | |
| (Printed name of participant) (Organisation) | (Signature) | (Date) |

| | | |
|------------------------------|-------------|--------|
| | | |
| (Printed name of researcher) | (Signature) | (Date) |

Appendix 8 Phoenix Evaluation

What difference does Phoenix make, and how does it do this?

Rebecca Hardwick, PhD researcher, University of Exeter.

R.j.l.hardwick@exeter.ac.uk

November 2016

About Phoenix

Phoenix is a building, a service and a community made up of and for people who have experience of mental health problems who are learning and helping others to learn how to develop self-management skills. There are two paid members of staff, Louise, who coordinates the learning centre and Gemma who is a Senior Support Worker. Other than that, the staff are volunteer Peer Trainers, people whose lived experience of mental health problems is the necessary qualification to train others. Peer Trainers provide informal support to one another, and provide training to people from the local community that come along to the courses to learn self-management skills. They also host three opportunities every week for people with lived experience, or their families and supporters, or for members of the general public to come along and talk about and learn more about mental health (Pop-up Cafés, Common Room). Peer Trainers also provide support and training at other services that are provided by Grace and CCT.

Phoenix exists to promote and support better mental health, and it achieves this for people who come in three ways: through the people there, the culture and through the self-management courses, where people learn about their mental health and ways to manage it better.

About this study

The purpose of this short study was to gather views on how Phoenix has made a difference in the lives of the individuals that are Peer Trainers. All current Peer Trainers were invited to interview and all accepted the offer. Interviews typically lasted 25 minutes, and were held in a quiet room at Phoenix. Participants were talked through the purpose of the study, what would happen to what they said and were made aware of what to do if they didn't want their data included, or wanted the interview to stop, or needed support or a debrief. A topic guide was not used, as the main purpose of the interview was

straightforward. All interviews were digitally recorded, transcribed by the researcher, and then deleted. Personally identifying information was removed from transcripts. Transcripts were imported into NVIVO for analysis. Transcripts were read and re-read and sections of them were coded inductively. Codes were then analysed thematically and written up. This work is part of an ethnographic study within a PhD that was granted ethical approval by the University of Exeter Medical School Research Ethics Committee, Reference: Jun16/B/073.

Findings

Who Phoenix helps?

Phoenix is for people who have experience of mental health problems, their friends, families and supporters. Those problems cover a wide range of experiences which are commonly classed as 'severe and enduring mental illness', and tend to include people being part of secondary care services, having a Consultant Psychiatrist and being on the caseload of a Community Mental Health Team. I spoke to people who had diagnoses of depression, anxiety, obsessive compulsive disorder, bipolar disorder, and post-traumatic stress disorder. They varied in their previous and current use of mental health services; some had been long term recipients of counselling, or of intensive residential and hospital based support, others had been largely trying to manage on their own, or had received support from the psychological therapies services, in particular working with a CBT therapist.

All of the Peer Trainers that I spoke to had been living with their mental health concerns for many years, some had used mainstream mental health care services provided by the NHS, or had approached other charities for support, but for various reasons at the point they came to Phoenix, most had reached the end of the road of support that was on offer to them elsewhere, or felt that the support from elsewhere was not what they needed.

People do not need to have a diagnosis or a referral to access Phoenix, unless they're attending a series of taster sessions, being run as a pilot for one local GP practice, and those I spoke to had come to know about what was on offer

via word of mouth from friends, fellow residents, other statutory services (Job Centre) or seeing a poster in their local surgery.

People are motivated to come to Phoenix, and then to become Peer Trainers for a range of reasons: initial motivation to attend Phoenix included wanting to attend a course and learn self-management skills; to receive 121 support; to volunteer and find purpose and meaning. A recurring motivation to be a Peer Trainer for all those I spoke to was wanting to 'give back' to Phoenix because they feel they have received so much.

I was very much of the generation that still, even with my tender years, [laughter], that, you know, depression anxiety was weakness, not illness, so for years you, ignored it, or suppressed it as best you could, and you know, I look back over my life and I think of what I learnt over the last two years. [...] you know you've got to come to a point where you've got to do something, you've got to change, so if I can help one person it's got to be worth it.

Outcomes

Oh I feel like I've climbed a mountain, from what I was then to what I am now.

I asked participants to tell me about the difference that Phoenix had made to their lives, what they were learning, how they had changed, or how their circumstances had changed since being part of Phoenix.

Participants talked about their own personal outcomes, in terms of improved mental health and wellbeing, as well as the learning outcomes from the courses. The mental health and wellbeing outcomes were due partly to what people were learning on the self-management courses, and partly due to being part of the Phoenix community. Where a participant specifically attributed an outcome as being a consequence of being on a course, it is highlighted "LO" (learning outcome).

Mental health and wellbeing outcomes

The mental health and wellbeing outcomes that participants told me they were achieving through being at Phoenix included:

- learning what works for me and how to take steps to support my mental health (LO)
- increased self-awareness (LO)
- sleeping better (LO)
- coping better with triggers (LO)
- how to challenge negative thoughts (LO)
- how to increase focus (LO)
- valuing personal lived experience and self-acceptance (LO)
- able to say no and be more assertive (LO)
- understanding my diagnosis better (LO)
- understanding others better: particularly self-harm (LO)
- different coping strategies (LO)
- to be more open and trusting with people
- managing to deal with long term, underlying emotional issues which had previously felt and been intractable
- feeling valued and worthy
- learning to recognise personal progress
- having a sense of purpose and meaning to life, a reason to live
- how to sustain my recovery
- recognising that I don't have to fake who I am

Several participants were largely house-bound before coming to Phoenix, their mental health was so poor that even leaving the house to go shopping was a real challenge and one they did not feel able to meet. Anxiety was the main cause of this, and despite people receiving counselling and CBT, it was through Phoenix that they began to change and go out more, with one person saying that they had recently returned from a foreign holiday, something which would have been unthinkable before going to Phoenix.

Going to Phoenix became a mechanism and motivation for getting out of the house; they did not say they felt obliged to come, rather that they didn't want to

let the other Peer Trainers down, and in particular, several said because they knew that at the end of the day at Phoenix, they would be feeling much better and happier.

I find if I'm just quiet and get on with what I'm doing, my energy, life, and happiness just builds up through the day, and I leave feeling much better. [...] If I hadn't come, Phoenix to come to, I'd probably just sit in my flat, and the more I stayed in my flat the more I wouldn't want to go out.

Improved personal or social circumstances (housing, work, self-confidence)

Through improving their understanding and management of their mental health and in receiving positive feedback on their work from others at Phoenix, Peer Trainers said they became able to improve their personal and social circumstances, such as their housing or work situation.

In the last 12 years I've been in hospitals and care homes, and a month and a half ago I moved to my own flat, and that was a huge move, and I wouldn't have been able to do it if I hadn't been here, I wouldn't have had the self-management skills, I wouldn't have thought I could cope on my own, I was very institutionalised, I thought I'd fall apart, so here, has taught me actually you have got the skills within you, you can do this, and we will support you [...] but here's the confidence, take it, you can do it.

Everyone I spoke to was or at some point had been in paid employment. For those not currently in paid employment it was their mental health that had led to them leaving their job. Becoming a Peer Trainer, and then providing the courses and supporting people at the Pop-In café's has increased confidence and skills for some to the extent that they have gained paid employment again, or started training courses towards paid employment. For others, their increased confidence has started to change their mind as to what they previously thought was possible, as this quote illustrates.

It just, it feels right when I'm here, when I'm, helping people, getting alongside them, and I get home and I am buzzing because I've really helped someone today, and that's really good. I never thought I'd work again, but doing this is really good and is making me think well maybe sometime in the future, I might be able to.

How Phoenix works

I was interested in understanding that if the Peer Trainers felt there was a difference in their lives from being at Phoenix, how had this happened or what was it that made that possible? Several interdependent factors were identified across the interviews: the people, the culture and learning from others/tools for change from the courses. The underlying theory of change seemed to be that if people are accepted where they are at, are valued and respected (demonstrated by how people behave towards each other) then they are able to learn how to manage themselves (through the self-management courses), because they start to see themselves differently. Furthermore, if they pick up (from others) and learn (from courses) self-management skills and approaches then their ability to manage their mental health and wellbeing improves and they are able to make positive progress because they know what to do.

Being understood and accepted by the people around you.

Experience of mental health problems bring with it isolation and social stigma, and those I spoke to have experienced both in their lives. Stigma and isolation feed off each other and lead to worsening mental health. Finding somewhere that you are included, despite your mental health experiences was incredibly important for the Peer Trainers, one described being at Phoenix as "coming into an unknown family, but it's a family that you've known all your life, and yeah, they just get you,". This feeling of belonging, and of having a place that was safe, and supportive was echoed by others.

One thing you want to do when you've got depression or a mental health issue is lock the door and stay there, but actually it's like having you know, a family who all have mental health issues and you walk in the door and they go, "Yeah I know, and actually how can we look after

you?", it's not like they're going to put pressure on you, and it stops the isolation which is the one thing you want to do.

Phoenix works by creating a safe space within which people are accepted as they are. The acceptance of you as you are is demonstrated by a phrase used by a few of the Peer Trainers: "The Power of Me Too". I asked one participant to explain it to me, and they said that the power was in knowing that the others around you understood your experience, and what it means to you, even if it wasn't their own experience; that you don't have to constantly explain and justify yourself, but instead are accepted as you are.

That was one of the things that really got me after I'd been here a few weeks, that they got me, and I don't have to fake who I am anymore.

Comments on how the paid workers approached the work highlighted a supportive, challenging, respectful and acknowledging attitude which sought to validate people's experience and feelings whilst at the same time continually encouraging them to find out what would support their own mental health.

The Culture

Closely related to the people at Phoenix, and feeling understood and accepted is the overall culture at Phoenix. Peer Trainers talked about a non-judgemental approach, that everyone has a part to play, and that their knowledge of their mental health is crucial and central to the work. Contrasting the approach elsewhere, one Peer Trainer commented that

Phoenix was like totally different, and they just like, the emphasis was more on self-management, whereas other places its more on "we know how you should get better, you will do as we want you to do" [...], they see your diagnosis, "this is the way you will get better", not "you need to find your own way, we'll give you the tools and the resources are within you", it's like you will follow our directives.

References were made to how some had used the way that the paid workers supported them to support their fellow Peer Trainers or people coming along to the courses or the cafes, which demonstrates that the culture of Phoenix, set by

the paid workers, may have been "caught" by the Peer Trainers and is then transmitted onto those that come to Phoenix for support. In an exchange with one Peer Trainer, they explained that the support they passed onto someone else was based directly on a conversation they'd had with one of the paid workers.

I guess this is the Louise influence [laughter] because I've heard her say in the past let people do what they need to do at that point. Um, and I guess she said when she was in [residential service], she had people who would just say in bed all day, and she'd be like yeah, ok, stay in bed, but give yourself a point where you say ok I've been in bed for three days now I've got to get up and go and I guess at the back of my mind that twitched, so I thought, I'll say that to her I'll give that to her.

When I asked her why she thought that approach would work, she said

I guess it's because you're not forcing them to do something they don't want to do. If they want to do that, you do that and there's no point saying no you should go for a walk, or go down the shop and get some shopping or go out with your husband and take the dog, if you don't want to do it you're not going to do it and you'll sit at home feeling guilty you've not done it. So if you feel that you want to stay in bed and that's the best you can succeed at that day, then why not? At least that's the impression I get anyway and that's what I picked up from Louise and I must admit I admire her from that, she doesn't mess around she comes straight out and says it, and it's true.

What this shows is that the overall approach to supporting people is meeting them where they are at, and that this approach is contagious; set out by the Community Manager, but adopted and adapted by the Peer Trainers.

Learning from others/ Tools to change

Crucially, whilst people are accepted as they are at Phoenix, they are motivated to be there and to participate because they want to make a difference: either to get well for themselves, or to support others. To do this, they use the self-

management courses (either as learners or trainers). On the courses, learners are given information about mental health conditions, and how they affect mental health and wellbeing, and different approaches to managing them. The courses can run from short 'taster' sessions of one to two hours, to 6 or even 12 week courses. There is no need for a referral to attend⁴, and learners can do as many courses, as many times as they like.

The courses are delivered by a professional trainer and a Peer Trainer, and they use a collaborative learning model, where participants on the course are invited to share their knowledge and experience with everyone, and are encouraged to participate fully. In conversation with trainers prior to conducting these interviews, a key element of the first session of any course is engaging people with "The Power of Me Too" ; a point at which learners realise that they are not the only one who has had these experiences, and that there is hope for change and recovery.

Participants in the interviews talked about the self-management courses in terms of their learning outcomes, and how they put that learning into practice as well in terms of their role as a Peer Trainer in delivering the courses. A contrast was drawn between the learning which they may have done in counselling or in CBT, or with their GP, which was seen as being a passive process, that kept you 'in your head', and didn't give you what you needed to change to experiencing training from people with lived experience, who could share what had worked for them, give suggestions of different things to try, encourage you to set your own goals, and importantly acknowledge the small steps you had made to wellness.

However, those that come to Phoenix are not given those tools with conditions that they *must* use them, that they *should* be improving and getting well: key to the approach seems to be a recognition that mental health recovery is a journey, that relapse or "bad days" are ok, and normal, and that there is always more that can be learnt.

⁴ Phoenix are currently running a series of introductory sessions, for people signposted from their GP surgery. Attendance at these introductory sessions is still not via referral, but is mainly for people coming from that practice, so that they can demonstrate to the practice how Phoenix can help.

So yeah, so I signed up to a self-harm course and a self-esteem course, and the place I was in at the time, I only managed the first two sessions of the self-harm course as it was too much and I actually ended up going into crisis and I couldn't come, and I felt awful about it but Louise was so supportive, I phoned her up and said I can't come, this has happened and she was so supportive and it wasn't, I thought "oh this is a failure", but the way it was reacted to was "you took the steps, you tried," cos I ended up self-harming loads, but the way it was dealt with, you know, "you've taken the steps, you do want to change," it was really empowering and really supportive, rather than "you're a failure you can't do this". [...] Whereas this is very much like celebrating the fact that you are on a journey, you are taking steps, you are trying, and not sort of like blaming you for not trying. So it's recognising that you did actually take some quite massive steps, which other people they see them as insignificant, but here they're recognised as like, actually, "that was quite difficult just walking through the door was a huge step".

I was told by some that they felt their small steps of progress "counted", so when things went wrong for them, or they didn't manage to successfully employ their learning, they weren't told off, or told they were a failure, or weren't trying, instead, the small steps they were taking were acknowledged and praised. This had a huge impact and for all who talked about this, it was the first time they said the effort they were putting into their recovery was genuinely recognised and understood.

Because other things I'd tried before, people had said before you're not trying, but to actually be told, we can see you're trying. Was like wow. Someone can actually see you're trying, I'm not giving in I am trying.

What could be done differently at Phoenix?

When asked what could be done differently at Phoenix, the comments were about promoting the service, increasing the number of and range of courses on offer, and reaching more people who needed help with managing their mental health.

Strengths and limitations of this study

This is the first study to evaluate the experiences of Peer Trainers at Phoenix, and as such offers a unique insight into what outcomes are being achieved and how that is happening; this will be valuable for the organisation going forward. As all Peer Trainers agreed to be interviewed, the findings can be held as representative of their views. However, Peer Trainers are those who have already benefitted from the self-management courses and who are 'on board' with what Phoenix is trying to do; for a fuller picture of what difference Phoenix makes, and how it works, it would be necessary to also speak to those who have participated in courses but not gone on to be Peer Trainers, as well as those who perhaps started to be Peer Trainers but have stepped away.

Further exploration of the interview transcripts may tell us more about the mechanisms of change, and what may be necessary to replicate or adapt from the model and culture of Phoenix to make it work in other places.

References and Bibliography

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