FIRST-LINE MANAGERS' EXPERIENCE OF THE USE OF AUDIT AND FEEDBACK CYCLE IN SPECIALIST MENTAL HEALTH CARE: A QUALITATIVE CASE STUDY

ABSTRACT

Background

Audit and feedback was the main strategy to facilitate implementation of The National Guideline for Persons with Concurrent Substance Use Disorders and Mental Disorders in specialist mental health services. Studies have shown that leadership support contributes to implementation success. The aim of the study was to explore how first-line managers in a District Psychiatric Centre experienced using audit and feedback cycle.

Method

The study had a qualitative case study design with individual interviews with five first-line managers from a District Psychiatric Centre in Norway. Qualitative content analysis were conducted.

Results

First-line managers were positive to contribute to better practice for the patient group and apply available tools. Four themes emerged: 1) Lack of endurance, where first-line managers saw their role as being process leaders, but failed to persist, 2) Lack of support in the process, where first-line managers called for a stronger organisational focus 3) Lack of ownership, where first-line managers felt the process was imposed on them, and 4) Lack of leader autonomy, where first-line managers seemed insecure about their role between professional leadership and own management.

Conclusion

First-line managers were not sufficiently experienced or equipped to solve the implementation process satisfactorily. They were torn between different commitments, without the autonomy to act as process drivers or facilitators, and without taking the necessary leadership role. The potential impact of the use of audit and feedback may thus not be fully realized, in part, because of limited organisational support and capacity to respond effectively.

Keywords: Audit and Feedback, Health Services Research, Evidence-Based Practice, Clinical Practice Guidelines, Quality Improvement, Qualitative Research

INTRODUCTION

Clinical practice guidelines[1] (CPG) are important foundations for evidence-based practice (EBP), produced to guide clinicians and managers in planning and delivery of health care and quality improvement (1, 2). There is a well-known knowledge-practice gap between what CPGs recommend as best practice and the actual treatment and care patients are offered by mental health care (3-6). The critical research-practice gap in mental health services necessitates implementation research to provide better services for patients (7).Implementation research may help to close this gap (8). The research field is rapidly growing, with a number of models and interventions to choose from to promote the use of CPGs, but there are still not one established strategy for guideline implementation in mental health care (9), although promising strategies exists (10).

One widely used intervention to facilitate implementation is audit and feedback (A&F). An A&F cycle is commonly used in different health care settings and may have a positive effect on health professionals' compliance with desired practice (11-15). The term is used for a heterogeneous group of interventions to improve the process and outcome of care (16). A&F interventions involve the development of a summary of some aspect of clinical performance (audit) over a specific period of time, and subsequent provision of that summary (feedback) to individual practitioners, teams, or health care organisations (17). The purpose is to prompt health care providers to modify their practice if practice is not in line with e.g. a CPG (14). It can be described as a circular process, an audit cycle, targeting health care professionals (12, 18, 19). The Norwegian National Guideline for Assessment, Treatment and Social Rehabilitation of Persons with Concurrent Substance Use Disorders and Mental Disorders (hereafter the National Guideline) was launched in 2012 (20). It contains 93 recommendations in areas of user involvement, families, assessment, treatment, follow-up care, roles and responsibilities and was developed for health care providers in either primary or specialist services. In conjunction with launching the National Guideline, implementation strategies based on the model of Grol and colleagues (21) were developed. A main strategy was an audit, an evidence-based strategy itself (14), designed for implementing the National Guideline to District Psychiatric Centres (DPC). One additional purpose of CPGs is to use them as benchmarks against clinical practice (22, 23).

Leadership is considered an important contextual factor, and leadership support is presumed to contribute to implementation success (24-30). Both transformational leadership focusing on inspiring

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[1] LIST OF ABBRIVATIONS: CPG - Clinical practice guidelines, EBP - Evidence-Based Practice, A&F – Audit and Feedback, The National Guideline - The Norwegian National Guideline for Assessment, Treatment and Social Rehabilitation of Persons with Concurrent Substance Use Disorders and Mental Disorders, DPC - District Psychiatric Centres, R&D nurses – Research and Development nurses (practice development personnel), CRT - Crisis Resolution Team, QI team – Quality Improvement Team

and motivating followers for a particular course of action, and transactional leadership, focusing on managing incentives and rewards and meeting quality standards are important for managing and supporting organizational change (31). In general we know little about first-line managers' actions in improvement processes (32). Although we know that senior or upper-level management often makes the strategic decisions about implementing EBP, it is the first-line personnel who drive effective implementation, thus better facilitated if led by first-line managers (27, 31). A large proportion of implementation and quality improvement projects are facilitated or entirely carried out by researchers, and there is therefore a need to explore these processes as naturally occurring in clinical settings, undertaken by local groups (33). To our knowledge, there are few studies on how first-line managers' experiences conducting a full A&F cycle in specialist mental health services. The aim of this study was to describe and explore how first-line managers in a DPC experience using A&F cycle as basis for quality improvement in specialist mental health care.

METHODS

Study design

The study was an instrumental case study, used to facilitate our understanding of A&F (34). The case itself is a natural process using A&F to implement the National Guideline. This article leans on two other articles describing various phases of the same A&F process (35, 36).

A qualitative method with individual interviews was chosen to understand the roles and experiences of first-line managers in an A&F process.

Study site

We looked for a natural occurring process and contacted DPCs about to implement the National Guideline by using a pre-existing audit strategy. One DPC was ready in 2014 and agreed to participate, and the study thus took place in this DPC in southeastern Norway. The DPC is an independent department within a hospital trust, with responsibility to provide specialist mental health care in a given geographical area. The DPC was situated in an urban setting and consisted of two outpatient and two inpatient units, offering adult specialist mental health services to a population of about 72,000. The two inpatient units had similar staff in terms of numbers and type and length of education, where nurses and social educators (both of whom have at least a three-year bachelor's degree) and assistant nurses are commonly referred to as "milieu personnel", while psychologists and psychiatrists are often referred to as therapists. The staff of both inpatient units consisted mainly of milieu personnel and 1-2 therapists. One inpatient unit had patients with psychosis-related disorders and the other had more patients within general psychiatry or personality disorders. One outpatient unit was a crisis resolution team (CRT), mainly consisting of nurses, social

educators or others with similar relevant qualifications, and had a psychologist and psychiatrist attached to the unit. They reached out from the hospital setting to patients mostly referred from GPs or other hospital departments. The second outpatient unit was operating as a general psychiatric outpatient clinic with regular hours and booked appointments, mainly staffed by therapists such as psychiatrists, psychologists or specialist nurses. All four units had patient with concurrent mental and substance use disorders and the National Guideline was therefore highly relevant to implement in this setting. The total number of staffs at the DPC was 63 (between 12 and 18 in each unit), not counting administrative or temporary personnel.

DPCs are often organised into three management levels: senior (executive) management led by Director of Division Mental Health Services at the Health Authority, middle management responsible for the DPC as a total, led by DPC manager and first-line (unit) management. Each unit had a first-line manager. First-line managers had the frontline staff reporting to them with personnel responsibility, HSE responsibility, shift plans, procedures and guidelines, budgeting, training plans for staff etc. Since 2001, there has been unitary management in Norwegian hospitals, replacing the traditional dual management structure based on a head nurse and a head doctor. The Health Personnel Act however, makes it clear that when cooperating with other health care professionals, the physician should make medical decisions on examination and treatment of patient (37).

The process

The main implementation strategy developed was an audit for DPCs mirroring the recommendations in the National Guideline, consisting of 46 questions about screening and diagnostic practices, assessment of the target group, integrated treatment, collaboration, use of evidence-based methods and competence requirements for e.g. the process of care. The electronic self-report questionnaire came with a standardised action form to be completed and a template for its use describing an A&F cycle: 1. Conduct the audit, 2. Identify improvement areas based on feedback, 3. Select improvement areas and define objectives related to the selected areas, 4. Choose measures to be implemented to achieve the individual goal, 5. Describe the progress of the various measures, 6. Describe who are main responsibility for the measures, 7. Make an economic assessment, 8. Implement the improvement work, 9. Evaluate whether the goals and measures are met in relation to the progress plan, 10. Perform a new audit. The audit with templates was available for the DPC at the website of the National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (38). There were no audit data nationally to benchmark against.

The senior management group wished to implement the National Guideline using the facilitated tools. The DPC manager made a common decision with the first-line managers in a DPC-management

meeting (DPC manager, four first-line managers, R&D nurses and administration manager) to implement the National Guideline with the use of the A&F cycle. The first audit of existing practice was conducted in 2014. A supervisor, not employed at the DPC, with responsibility for concurrent mental and substance use disorders, assisted in the practical execution of the audit. Each eligible (all staff excluding administrative personnel, short-term temporary staff etc.) employee conducted the audit. Each unit held separate meetings led by the supervisor, where feedback of the results was given at a unit level verbally and in writing to the whole staff group present. The meetings included information on EBP, on recommendations in the National Guideline and on how to conduct an implementation process informed by the A&F cycle. The first-line managers were present at all the meetings. The first-line managers selected members for multidisciplinary quality improvement (QI) teams for each unit. The teams reflected on the feedback from the audits and worked to complete action plans for the following year. A final decision on the areas for improvement and action plans was made in a management meeting for the entire DPC in 2014 and the following common areas were chosen: 1) Screening of alcohol and drug use, 2) Enhanced knowledge of the treatment of concurrent substance abuse and mental illness, and 3) Improved collaboration between the DPC, substance abuse departments in the health authority and local authorities (35). The actions were initiated the following year with the first-line managers responsible for their implementation. Some of the actions, such as training courses, were planned and organised by practice development personnel (R&D nurses). A re-audit led by the same supervisor was conducted in June 2015. Feedback of the results was given to the management in 2015 and was planned forwarded by the unit managers to the staff immediately afterwards.

Participants

Participants (n=5) for the interview were all of the first-line managers, all with a background as registered nurses and several years of experience as managers. One unit manager was new to the organisation. There were four women and one man. One unit had a vacancy for the post of first-line manager at the commencement of the A&F process and was led by the DPC manager who then had a double role for a few months. A new first-line manager was in place a after a few months, taking over the responsibility for the process. Both the DPC manager (in the role as first-line manager) and the first-line managers were interviewed to obtain as rich and accurate data as possible.

Data collection

The interviews were conducted when the full A&F cycle had been completed, one year after commencement of the process, shortly after the final re-audit. An open interview guide focusing on the complete A&F cycle was created, drawing on observations of the QI team meetings in 2014 (35)

and on literature on A&F cycles and in the field of implementation leadership. It covered broader areas like usefulness, what is done, experience of the whole process, A&F as leadership tool, what could be done differently (barriers), what would you do again (facilitators), have you changed the way you work because an A&F-process, are your more conscious of own/staffs practice etc. The interviews took place in 2015, lasted for about one hour and were conducted by the first author (MSP). Summary of the main points and follow-up questions ensured validation and ascertained that the information was understood. The interviews were audio recorded and notes of reflections were made immediately after each interview. All interviews were held at the site of the DPC, in the managers' own offices.

Analysis

We used qualitative content analysis as described by Graneheim and Lundeman (39), a method suitable for the systematic analysis of communication. It enabled a focus on both context and subject matter and emphasised both similarities and differences. The aim was to condense and describe the phenomenon and the outcome of the analysis in categories sharing the same meaning (40). Since the purpose of this study was to learn more about how first-line managers describe and experience the use of A&F as an implementation strategy in specialist mental health care, we decided on a mostly inductive content analysis. No pre-existing analytical framework was used, as recommended when there is insufficient or fragmented knowledge of the phenomenon (40), but we used the interview guide as a guiding framework in the beginning of the analysis.

The audio-recorded interviews were transcribed verbatim and the NVivo 10 software was used to facilitate the analysis (41). The material was read several times to gain a sense of the whole, and to gather ideas for further analysis. The text was divided into meaning units, which were examined and condensed with the key content preserved and coded. The codes were then sorted into categories grounded in the data and representing the manifest content of the text (39).

RESULTS

All the first-line managers with no exception expressed a positive attitude towards A&F as a strategy for implementation. They saw the A&F as an important management tool to show needs regarding staff skills and gaps between an actual practice and a practice more in line with the National Guideline where it helped to focus on important improvement areas. They would like to use A&F more and in other areas as well.

All four units experienced being in another, and qualitative better professional place than before the process, and the results of the second audit showed that improvements had been accomplished for all units in all the areas they decided to improve on in the chosen areas. Still, some of the participants

did not necessarily believe in great improvements. One of the leaders expressed scepticism about whether the process actually resulted in improvement of practice, questioning whether the A&F process was worth the effort.

> *"But whether we've actually got that much better at treating substance abuse…"*

In the following results we present the themes most prominent when the first-line managers elaborated on the A&F process.

Four themes emerged: 1) Lack of endurance, where the first-line managers saw their role as being process leaders, but they failed to persist, 2) Lack of support in the process, where first-line managers called for a stronger organisational focus 3) Lack of ownership, where the first-line managers felt the process was imposed on them, and 4) Lack of leader autonomy, where the first-line managers seemed insecure about their role between professional leadership from therapists and own management of the unit.

Lack of endurance

The first-line managers saw themselves as the ones who had to keep a grip on to the A&F cycle and make sure it was completed. That included having task focus, reminding staff of their tasks and responsibilities, and following up on the action forms completed in the initial phases, i.e. facilitating the process and leading it forward. One of them delegated parts of this work to dedicated members of staff, who organised training courses for the unit. Some expressed a wish to delegate, but most of them saw the work as a first-line manager's responsibility and an important part of their role.

> *"And I can see that I have to be the one who promotes this, to a great extent. Like keeping it warm, you know."*

Most reported difficulties in persisting and keeping focus throughout the whole year. Their schedule was always tight, and there were many things to distract them from decisions made on areas for improvement. They felt trapped in a hectic clinic, managing and administering their units and staff. The first-line managers were clearly more eager at the beginning of the A&F cycle than in the completion phase. Therefore, although the first-line managers saw their role as the ones to keep a grip on the process, it was also here they strayed off the path. They lacked the endurance to follow up on the decisions made at the outset.

> *"But we're also affected by what happened last week and the process we're in the middle of, and so on."*

Lack of support

All of the first-line managers reported lacking support from the management level above. Some said the A&F process had been totally absent from the DPC management meetings, and requested a stronger organisational focus in the DPC as a whole and a forum for discussing the process. In particular, they asked for reminders, "someone" to remind them of the implementation process they were involved in, asking for a status report from time to time.

> *"There hasn't been enough leadership support. You might say I think I've done what I could with it, but if you think about our management meetings, there's not been much focus on it. But I suppose it's been because everything else has been taking away the focus. So I can't say there's been much focus on that [the A&F cycle], really."*

> *Q: "Do you think you've been given the leadership support you need to help your staff to ..." Manager: "In this thing? In the audit process?" Q: "Yes" Manager: "No, not at all!"*

There was no doubt that the lack of support the first-line managers experienced gave the implementation process less attention, less power and less leadership than they felt it probably should have had. The A&F cycle fell into oblivion, the first-line managers forgot their self-proclaimed role to support staff on the decisions they made at the beginning of the process and to remind them and inquire about the development of the implementation.

> *"Yes, well, a bit shocked that, well, are we forgetting all about it or what, what's happening to us. So it was good to be reminded about it the day we got the results from the audit and I started to think now I've got to do something."*

The first-line managers were pleased with the practical support they received in the execution of the audit and the preparation and facilitation of the feedback reports by the supervisor, and with the administration of training courses by the R&D nurses. One of the first-line managers expressed some disappointment with the R&D nurses, pointing at the need for closer follow up in the ward and more process responsibility. They all appointed members to QI teams at the beginning of the process, which was necessary as part of the implementation strategy, but none of the managers seem to have used or involved these groups further in the process to any great extent.

Lack of ownership

This implementation process with the use of an A&F cycle was decided at a hospital and DPC level. The first-line managers were invited to decide whether they wanted their unit to be part of the process, and they all decided to participate. Nevertheless, some of the first-line managers claimed that the A&F process with all its actions was imposed on them.

"You could say we really don't have any choice about it, but in saying that, I do actually think it's a good thing."

Although mainly viewed as positive, there were statements indicating a feeling of being run over, and not being understood. They stated that various areas of hospital and government priorities, and particularly clinical guidelines, were always top-down initiatives from higher authoratives that expected them to be implemented in the clinic. These clinical guidelines were not necessarily seen as an aid to enhance clinical practice or improve quality, but more as directives from "above".

"I think it's a problem in the health care system. That so much is initiated from the top. And they think we're just sitting here and looking at each other and having a nice time. And they don't realise that just one more thing, in fact that can be the straw that breaks the camel's back."

The first-line managers felt loyal to the A&F process and basically went along with what they were required or expected to do, but lacked ownership and did not necessarily find it satisfying. A few of the first-line managers definitely wanted more of a say in the matter in their own unit. But when asked specifically about this, they sometimes referred more to the lack of time than the question of increased autonomy as a first-line manager.

"I'd like to be able to decide more, I'd like more autonomy in terms of what I think we can really manage to do something about. Because nothing happens properly when we carry on like we've been doing this past year. There's an awful lot to do, we get all these directives raining down on our heads and then you just have to make what you want out of it. And I'm not happy with that."

Lack of leader autonomy

The first-line managers, except the one from the general outpatient clinic, said that completion of an A&F cycle had led to increased discussion of practice in general in the units. Mainly, but with the exception of the general outpatient clinic, they had faith in an A&F cycle creating increased awareness of best practice and of clinical guidelines as a standard for EBP. Nevertheless, many practice decisions were still made by the therapists alone. One of the participants felt that the A&F had led to more and better discussion with a more confident staff, but decisions, even small ones concerning practice, were still easier to make when a therapist was present because someone (e.g. the therapist) could take responsibility for making the final decision. She also said that the decisions were never written down and not necessarily related to clinical guidelines or local procedures, but were based on experience and the therapist's opinion and putative knowledge.

"Oh, definitely, yes, the rest of the staff has enough knowledge to take part in treatment discussions with therapists. I've found that it gives all the staff more expertise, you know. Incredibly useful discussions and assessments. And then when we end the discussion, we've finished it and we've achieved a result. While before we could sit discussing and discussing and we never agreed and finished, it just remained there. But now we wrap up the discussions; okay then, we'll do that then, that's fine."

Therapists play a key role in the treatment of patients as they are professionally and legally responsible for medication and the course of treatment. Some of the units had experienced unstable situations with new doctors coming and going at a fast pace, never allowing for the development of stable relationships with the rest of the staff. An otherwise competent staff with considerable knowledge and experience leaned back and waited when a new therapist arrived. The staff had no tradition of taking a lead and telling the therapist, "in this unit we're working on these principles of treatment and EBP".

"While we, the staff, have the feeling that here comes a new consultant, how is he going to want things to be? Will he want things like they are here now or will we have to change again?"

The first-line managers did not take a leadership role either, to explain the principles the unit was run by. Instead, they defined themselves as part of the staff in terms of these decisions. This was particularly present in the in-patient units. Further, the firs-line managers largely ignored the leadership role in the choice of treatment profiles and strategies in the unit. In this area they also seemed to lean back and leave the decisions almost entirely to the therapists alone. They did not intervene or profile their unit with the treatment strategies they followed, and made no effort to promote the use of clinical guidelines or EBP. This was left to the therapists alone. Some, however, had a desire to contribute to these decisions without necessarily seeing solution.

"So I'd like to create a ward with much more of the treatment based on milieu therapy, where the consultants obviously have some influence, but they must also realise that this is actually how we want to run things in this ward."

DISCUSSION

All four units had important improvements according to the re-audit, most of the planned actions were fulfilled, but although positive attitudes towards A&F as a strategy, the process as such was still not seen as a completely successful process. This brought up four main themes of the experience of the process: 1) Lack of endurance, 2) Lack of support in the process, 3) Lack of ownership, and 4) Lack of leader autonomy.

This study told a story of first-line managers who were willing to contribute to better practice for a group of patients with concurrent mental and substance use disorder traditionally not receiving best practice in specialist mental health care. They also applied available A&F tools, but we found managers who relinquished responsibility both to their staff and to the managerial level above, thus not fulfilling their responsibility, which was more easily taken in the initial stages of the process than in its completion phase. First-line managers do not seem to be sufficiently experienced or equipped for solving this task regarding implementation processes using A&F or to have an adequate understanding of their role.

The first-line managers saw their role as the ones to lead the process, but this was also where they strayed off and lost focus. They reflected on pitfalls they came across in attempting to complete a full A&F cycle throughout a whole year; many other tasks were always claiming their attention. An important dimension of the Consolidated Framework for Implementation Research (CFIR) is to allow time for the implementation to take place (29), also emphasised elsewhere (42). This is also called perseverant leadership, and is one of the domains in the Implementation Leadership Scale (ILS) (43). They were not able to preserve through vicissitudes of implementing recommendations from the National Guideline or carry on through the challenges, as described in the ILS, according to themselves.

It is not possible to see the lack of endurance as a stand-alone-failure on behalf of the first-line managers. Their role was claimed to be that of process leaders, but they found they were alone with the task, without the necessary organisational support, and they felt a lack of leader autonomy in attempting to fulfil the A&F cycle. We interpreted this partly as a time barrier, releasing less time for leadership than needed, also shown in studies on barriers (44). This is also described in qualitative studies where a growing administrative workload sets little time aside for working on improvements, despite an initially positive attitude by the management (45). A Swedish study in mental health care found that the time barrier was only present in the clinics who had only received a guideline, whereas the clinics with an active implementation strategy did not report a time barrier (46). They assumed this to be due to the organised approach of intervention clinics trying to change and develop practice. This would support an explanation of lacking organisational support for the A&F process initiated a year earlier. Lack of supportive conditions, e.g. lack of leader support and focus in management meetings emerged to prevent optimal fulfilment of the A&F cycle and thus may also have hindered an optimal implementation of the National Guideline. Organisational commitment, involvement and support are crucial when initiating an improvement process. There is a risk of impeding the implementation process if executive managers don't involve lower levels of management or pay attention to how the process leadership is utilised (27). The need for

implementation competence and support for mangers has also been described in other studies (30, 32, 47). Some qualitative studies addresses the importance of the work process, and to have a process facilitator is amongst the recommendations to accomplish a A&F cycle, (48-50)

It is possible that the managers are disclaiming their responsibility when they discovered in the end of the A&F cycle that they had lost focus and strayed off the planned path. The process was well organised with management commitment at several levels and baseline A&F, combined with instructions on how to run an implementation process and the use of QI teams from the clinic to engage in the process, all important constructs within the CFIR framework of planning and engaging that are believed to enhance success (29).

It is vital for managers to have knowledge of EBP and reasons for the use of clinical guidelines in order to ensure high-quality patient outcomes (51). This study indicates that first-line managers sometimes view national clinical guidelines more as a never-ending load of instructions coming from the authorities than as help to ensure good practice and best possible patient outcomes. This attitude could well act as hindrance to leading the implementation of national clinical guidelines by the use of A&F. It is thus vital to teach first-line managers about EBP in general and the importance of the use of national clinical guidelines to enhance practice. This may also, in addition to lack of supportive climate in the organisation, suggest a lack of knowledge of EBP and CPG as a source of EBP. Knowledgeable leadership is one of four domains in the Implementation Leadership Scale (43) and an important feature of an effective implementation leader. The use of evidence-based clinical guidelines is one way of making available and ensuring evidence-based mental health services (1). Leaders play a key role in supporting EBP (27, 52).

Instead of talking about cooperation and teamwork, the first-line managers mostly talked about stakeholders in the decision-making processes, who were not always easy to deal with. They seemed to have a vague perception of their role as first-line managers, caught between everyday administration and management of staff, their own leadership and consultants' formal and informal leadership, and the management level above. Staff in mental health care has previously reported ambivalence and lack of support from senior medical staff in relation to A&F; at eight months post-implementation, a significant number of nurses remained ambivalent about the benefits of the outcome measurement and had not engaged in the process (53). There are reasons to believe that first-line managers have the same kind of experience.

This tells a story of complexity in organisations, and the difficulty of separating the interwoven actions between managers and the context, which has also been found elsewhere in a search for leadership actions associated with successful improvement (32). Managers cannot, or should not,

dictate consultants how to work with patients, but they can facilitate the use of evidence-based clinical guidelines as a source of summarised evidence on best practice adapted to the national context. When this process was decided upon in 2013, it was an administrative management decision. All the managers at first- and middle-management levels were nurses, and to our knowledge the “medical management” was not involved in the decisions. This might have caused some of the lack of autonomy experienced by first-line managers. Consultants play an important and unique role in bearing the final responsibility for the patient and are thus a key element of the team around the care process (54). The process of implementing the National Guideline using the A&F strategy could possibly have gained from involving the medical leaders into the formal process to a larger degree.

Strengths and limitations of this study

A major strength of this study is the natural setting of the study, reflected a real world setting without a researcher being part of the project. Given the naturalistic approach, a limitation is the possibility to replicate the exact study design, involving the entire process, although the study is based on a DPC that used the toolkit made nationally available for DPC in Norway to ease implementation of the National Guideline, and the study site may be considered an average DPC in Norway. Further limitations could be the relatively small number of study participants and the lack of pilot interviews because the case boundaries was set and excluded the inclusion of more participants as this was all the first-line managers available in the case. Qualitative research is however, not aimed to be generalisable, but to provide rich description of findings within the context of the study setting. This might allow determining the transferability of the findings to other contexts. There will be a possibility of recall bias when reflecting on a process over a whole year. This was taken care of at the beginning of each interviews, where the interviewer summarised the formal process in the DPC from initiation and first audit throughout the actions taken and results of the re-audit. We decided to include only the first-line managers’ perspective to be as close to the actual process as possible. This might have led to loss of some overarching perspectives, but we do think it led to a deeper understanding of this particular level of management.

Implications

Qualitative case studies in a natural clinical environment are important to understand how implementation strategies are absorbed in real life. This study may contribute to development of better A&F processes and to a better understanding of organisational challenges that must be taken into account when planning an implementation process. Particularly the challenges first-line

managers in daily operation meet, suggesting stronger organisational assumption of responsibility to equip them better for the task.

Conclusion

This study told a story of first-line managers who were willing to contribute to better practice for a group of patients with concurrent mental and substance use disorder traditionally not receiving best practice in specialist mental health care. They also applied available A&F tools, but we found managers who relinquished responsibility both to their staff and to the managerial level above, thus not fulfilling their responsibility, which was more easily taken in the initial stages of the process than in its completion phase. First-line managers do not seem to be sufficiently experienced or equipped for solving this task regarding implementation processes using A&F or to have an adequate understanding of their role. This A&F process seems to be set out properly according to known best practice of quality improvement and implementation processes. Still, the first-line managers seemed to have a vague perception of their role, caught between everyday administration and management of staff, their own leadership and the consultants' formal and informal leadership, and the management level above. The potential impact of the use of A&F may not be fully realized, in part, because of limited organisational structures and capacity to respond effectively.

There is still a need for more research in this area in the form of effect studies and testing of theories, and also for qualitative studies in a natural clinical environment.

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