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Observing Practice Leadership in Intellectual and Developmental Disability Services

Abstract

Background

Improving staff performance is an issue in services for people with intellectual disability. Practice leadership, that involves the front-line leader of a staff team focusing on service user outcomes in everything they do, as well as coaching, modelling, supervision and also organisation of the staff team, has been identified as important in improving staff performance, although to date this is based on self-report measures.

Methods

This paper describes and tests an observational measure of practice leadership based on an interview with the front-line manager, a review of paperwork and observations in 58 disability services in Australia.

Results

The measure showed good internal consistency, and acceptable inter-rater reliability. Practice leadership was associated with staff practice and outcomes for service users. The Observed Measure of Practice Leadership appears to be a useful tool for assessing whether

leadership within a service promotes enabling and empowering support by staff. It was found to discriminate higher and lower performing services in terms of active support.

Conclusions

The measure had good reliability and validity although some further testing is required to give a complete picture of the possible uses and reliability of the measure. The measure is potentially useful in contexts of both research and service development. The confirmation of previous findings from self-report measures, that practice leadership is related to the quality of staff practice and outcomes for service users, has implications for policy and practice in terms of the training of managers and structures for organisational management.

Key words

Intellectual Disability, service development, practice leadership, active support, person-centred.

Introduction

Factors involved in successful implementation of person-centred staff support

Implementation of good staff support practices in the field of intellectual disability, in particular active support, has not been easy or straightforward (Mansell & Beadle-Brown 2012). Mansell et al. (2008) found that, generally speaking, most structural, organisational and management factors were only weakly associated with good staff performance and therefore with good outcomes for users. This led Mansell et al. to suggest that perhaps there were some specific management practices that were more important. In the wider management context, one element of successful organisational change, as identified, for example, by Kotter (2007), was the development and communication of the new vision and way of working needed to achieve that vision. Kotter (2007) comments that "most of the executives I have known in successful cases of major changes learn to "walk the talk". They consciously attempt to become a living symbol of the new corporate culture"

Focusing on leadership in disability services specifically, previous research across a number of countries had also concluded that the quality of front-line management was an important determinant of staff practice, but that the role is multi-faceted and complex (King et al. 1971; Hewitt et al. 2004; Larson & Hewitt 2005; Beadle-Brown et al. 2006; Larson et al. 2007; Clement & Bigby 2007). Like Kotter (1995), Schalock and Alonso (2012) also refer to the role of a good leader as "performing critical leadership functions related to communicating a shared vision that answers the question 'what do we want to create?'"(Page 8). They highlight the role of a leader in "encouraging and supporting staff to grow and develop insights and skills, stressing a systems perspective that focuses on…enhancing a person's quality of life".

In the U.S. context, based on a number of studies, Hewitt and Larson (2005, p 133) concluded, that "…for direct support professionals, it is the front-line manager who defines

the job, provides the training, mediates the stresses, creates the culture, helps people find the personally satisfying rewards… and establishes a well-functioning work environment". Larson et al. (2007) identified 142 front-line manager competencies in 14 domains, most of which were validated by Clement and Bigby (2012 in an Australian study. The domains included the role of front-line managers in supporting service users directly and therefore demonstrating good practice to other staff as well supervising staff on an individual and team basis. The list of competencies identified, although broader than practice leadership, did not encompas all aspects of practice leadership that Mansell et al. (2004), Ashman et al. (2010), Clement and Bigby (2010) and Mansell and Beadle-Brown (2012) maintain as important in supporting the implementations of person-centred action such as active support . In particular, although both Hewitt and Larson and Clement and Bigby include a domain of modelling good practice in the direct support work with individuals, neither conceptualisation specified coaching as an important element of the front-line manager's role. In addition the competency frameworks do not make clear the nature of the practices that front-line leaders should be leading.

Defining practice leadership

Drawing on the previous research noted above, a practice leader can be defined as an individual (usually a front-line manager) who develops, encourages and supports their staff team to put into practice the vision of the organisation. Schalock and Alonso refer to four leadership roles needed in disability organisations: 1) mentoring and directing, 2) coaching and instructing, 3) inspiring and empowering and 4) collaborating and partnering. Elements of leadership such as modelling and coaching have long been recognised as important techniques for shaping skills and behaviour in many fields of health and human services (Cherniss 1980; Werner & DeSimone 2006; Anderson 2013) as well as intellectual disability services (Schalock et al., 2008; Ashman et al., 2010). Following Cherniss's

conceptualisation, Mansell and Beadle-Brown (2012) described the model of practice leadership needed to deliver high quality support in intellectual disability services as involving skilled professional advice and assistance as well as administrative control, and an educational and developmental role rather than simply providing direction. Mansell, Beadle-Brown and colleagues (Mansell et al. 2004; Ashman et al., 2010; Mansell and Beadle-Brown, 2012; Beadle-Brown et al., 2013), operationalise the role of the practice leader further, with specific reference to the field of intellectual and developmental disability and in particular within the context of active support.

> "Practice leadership can be defined as the development and maintenance of good staff support for the people served, through:
>
> • focusing, in all aspects of the front-line leader's work, on the quality of life of service users and how well staff support this;
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> • allocating and organising staff to deliver support when and how service users need and want it;
>
> • coaching staff to deliver better support by spending time with them providing feedback and modelling good practice;
>
> • reviewing the quality of support provided by individual staff in regular one-to-one supervision and finding ways to help staff improve it;
>
> • reviewing how well the staff team is enabling people to engage in meaningful activity and relationships in regular team meetings".

The impact of practice leadership

Despite the fact that the role of the front-line leader has been proposed as important for performance of staff teams across many countries (Burchard et al., 1987; Burchard &

Thousand, 1988; Lakin, 1988; A. Cohen, 2000; Hewitt, Larson, & Lakin, 2000; Hewitt et al., (2004); Janssen and Van Yperen, 2004; Packard, 2009), there is little published empirical work on the impact of the particular aspect of practice leadership on the quality of staff practice and outcomes for people with intellectual and developmental disabilities. Beadle-Brown et al. (2013) found that staff rated quite low the practice leadership they received from front-line managers. Beadle-Brown et al. found that while practice leadership appeared important in explaining changes in levels of active support over time, it was more effective in the context of good general management. This study used a staff rated measure that allowed the calculation of a 12 item practice leadership index. The authors noted that an observed measure of practice leadership was needed to supplement staff perceptions which may be limited by experience and expectations of managers. Another issue to be considered is that identifying the influence of front-line managers is made difficult by differences in the way organisations structure these positions, in terms of breadth of responsibilities and proportion of work specifically focussed on leadership of practice. For example, in Victoria, Australia, some organisations have a dedicated front-line manager for each supported accomodation service, who is responsible for some adminstrative tasks, elements of practice leadership as well as direct support of service users for a fraction of their time. In contrast in other organisations front-line managers are responsible for two services, have greater administrative responsibility that may include staff recruitment, but not for provision of direct support.

Aims of the study

Methodologically, the measure of practice leadership used by Beadle-Brown et al. (2013) was limited to self-report. This carried the usual biases such as social desirability, and different interpretation of the meaning of questions, sometimes due to regional variation in

terminology and which added to the lack of correspondence between staff and front-line managers. These limitations prompted the development of an observational measure.

Having spent a number of years developing and piloting the Observed Measure of Practice Leadership, this study tested the measure with a sample of 58 services across 9 organisations. It aimed to establish the reliability and internal consistency as well as describe the extent of practice leadership and the relationships between practice leadership and the quality of staff support. In summary the research was guided by the following questions: 1) What are the psychometric properties of the Observed Measure of Practice Leadership? 2) Is there a relationship between scores on the practice leadership measure and measures of the quality and frequency of staff support and outcomes for those they support? 3) Does strong practice leadership discriminate between services in terms of quality of staff support?

The term 'front-line manager' is used to refer to the individual who has direct line responsibility for leading the practice of staff on a day to day basis. As suggested earlier, this role may be combined with other responsibilities across one or more services. In other contexts this individual might be referred to as the house supervisor, the home/ house/service manager, or occasionally the team leader.

Methods

Participants and settings

Data were collected between September 2012 and June 2013 in 58 supported accommodation services across nine organisations providing support for 241 people with intellectual disability. An audit of the service users of each organisation had been completed prior to the collection of data to provide demographic information, a measure of adaptive functioning (using the Short Adaptive Behaviour Scale, (Hatton et al. 2001), a measure of challenging behaviour (the Aberrant Behaviour checklist, (Aman et al. 1985) and information on communication. Consent was gained for 189 people aged between 16 and 76 (mean 42

years). Just under half (49%) were male. The sample was relatively able with a mean Adaptive Behaviour score of 139 (ranging from 22 to 263). Reported levels of challenging behaviour ranged from none to a score of 110 on the Aberrant Behaviour Checklist with relatively low average levels (mean ABC score = 25). Thirty five percent of people were recorded as having a physical impairment and 32% were reported by staff to be non-verbal.

One organisation was a regional branch of a government department and the others were not-for-profit agencies. The length of implementation of active support varied across the nine organisations, from one organisation that had begun in 2012 and several others that had over 10 years' experience.

Measures and procedure

Quality of support and outcomes for service users

The Active Support Measure (ASM) was the main measure of the quality of staff support (Mansell and Elliott 1996; revised Mansell et al. 2005b) that is completed for each service user observed. This 15 item measure focuses on the opportunities for involvement and the skills with which staff members provide and support those opportunities. Each item is rated on a scale of 0 (poor, no activities provided/no contact from staff), 1 (weak, inconsistent support/performance), 2 (mixed performance) and 3 (good, consistent support/performance).

The momentary time sampling measure of engagement in meaningful activities and relationships (EMACR) (Mansell and Beadle-Brown 2005) was used to measure the experiences of service users. Observers code both social and non-social activity (self-care, household or work, audio-visual or leisure), assistance and other contact from staff, contact from other service users and challenging behaviour (self-stimulatory, self-injurious, aggressive or destructive or other challenging behaviour). Both measures are described in detail in other published papers (Beadle-Brown et al. 2012; Mansell et al. 2013).

Observations were conducted usually between 4 and 6pm, using a one minute time interval and rotated around the consenting service users present every five minutes. The ASM was completed by the fieldworker for each individual at the end of the observation using all the information available from the two hour observation.

The main information from the measures used in this paper is 1) the overall ASM score, on which percentage scores for each individual were also categorised into " good, consistent performance " (percentage score over 66.66%), " mixed performance " (a score between 33.33 and 66.66%) and " weak inconsistent performance " (a score below 33.33%). As reported in Mansell and Beadle-Brown (2012, Chapter 3), using the categorisation of good versus mixed/weak active support reliably differentiated individuals and groups in terms of outcome measures such as engagement and other measures of quality of support (Beadle-Brown et al., submitted).) 2) the percentage of time service users received assistance from staff to be engaged in meaningful activity from staff during the 2 hour observation, and 3) the percentage of time service users were engaged in meaningful activity (including social interactions). Observational data was available for 171 people.

Practice leadership

The Observed Measure of Practice Leadership was developed over a number of earlier phases. The first version was piloted and reliability assessed in 31 services in Victoria, Australia. Following this, the measure was revised slightly and the guidance for researchers expanded using examples from the pilot study. The measure was used again in 30 of the same services 12 months later. Data were collected by the two original and two additional specifically trained researchers. Researchers were trained both in the concept of practice leadership and the tool itself, the latter involving sessions going through the tool in either a group or one-to-one session and in situ, conducting observations along-side an experienced observer and having the chance to compare ratings and discuss issues that arose. Inter-rater

reliability was checked by the first author using the observational field notes, descriptions of paperwork examined and interview transcripts for 19 services. Reliability was found to be good on all domains, although with a little variability across domains - Average Kappa value across the five domains was 0.63 with no domain having a Kappa statistic of under 0.50. Internal consistency was high (Cronbach's alpha = 0.925).

In the final measure the observers rated the evidence of practice leadership in the 5 core aspects of the definition provided in the introduction, but with the overall focus of the front-line manager being the last of the five items to be rated. The ratings were made on a five point rating scale (with 1 being no or almost no evidence of the element being in place to 5 being excellent- could not really improve on this element), on the basis of a number of elements: unstructured observations of the front-line manager during the visit to the service; semi-structured interviews with the front-line manager, and where possible, with direct support staff; and review of paperwork associated with practice leadership such as staff allocation and minutes of team meetings. Interviews with front line managers lasted approximately one hour and explored their perceptions of the aims of the service, their priorities as front-line managers and the systems and processes in place to support staff and to develop the quality of their practice. Success and challenges were also explored. Interviews with staff present on shift, where it was possible without disrupting the support received by service users, explored how staff knew what to do when on shift and their perception of what was prioritised by their front-line manager. These interviews lasted between 5 and15 minutes. Unstructured observations of practice leaders lasted between 20- 60 minutes, and focused on the roles they played during this time, interactions with staff and residents and their physical location within the service.

The measure itself with the guidance for how each aspect might be rated can be seen in Appendix 1.

In the current study the measure was completed with 46 front-line managers (ten of whom had responsibility for two services), using the same methods of data collection as the previous trial, described in the appendix. Observation of the front-line managers was possible for 44 of the 46 front-line managers interviewed. Because of low staff ratios interviews with staff on shift were not feasible in many of the services. All interviews were digitally recorded, and detailed field notes written as soon as possible after each visit. After reviewing all the data the fieldworker scored the five items on the measure.

Given high internal consistency, total scores across the five domains, mean scores and percentage scores were calculated in addition to scores for each domain (maximum score of 5). An overall mean score of above 4 means that practice leadership is strong on most domains, below 2, represents consistently weak practice leadership, and scores between 2 and 4 illustrates a mixed picture.

The observations to complete the ASM and the Observed Measure of Practice Leadership were carried out on different days and by different researchers so that there was independence in the data. Thus each service had two visits, usually within 2 months of each other although in four services circumstances meant there was a longer gap of 3 to 4 months.

Observer training and inter-rater reliability

Data on service user engagement, the frequency of staff assistance and the ASM were collected by 3 observers. The main observer (third author) collected data in 44 services, the second observer in 10 services, and one other observer in 4 services. Most observers had used these measures in previous studies and all had been trained by the first author. Training included classroom based training on active support and the nature of engagement, observer

discipline and on the observational categories and the definition of each of the 15 questions of the ASM. Practice observations using video clips were conducted and codes discussed to ensure understanding and agreement. Each observer also conducted in situ observations with the trainer for at least 2 hours, usually in a day centre or sheltered workshop but also in a smaller supported accommodation service if only one or two observers were being trained at a time. Reliability was checked roughly after an hour and issues discussed and then a second hour conducted together and reliability checked and agreement on ASM checked and issues discussed. Each observer did at least one further buddy observation with the main observer (3rd author). Inter-rater reliability on the EMACR between the main observer and the first author was rechecked before the study began and was high (Kappa 0.81 over 88 minutes of observations). Reliability on the ASM was not conducted in this study due to the small number of individual people observed. The second observer had been trained in the UK by the first author and had already shown good reliability in previous studies. She had a refresher session with the main observer before conducting observations for the study.

Data for the practice leadership measure was collected by 4 observers who had a good awareness of active support and had experience of working in services for people with intellectual disabilities in some capacity. They were all trained on the measure by one of the authors and generally conducted at least 2 visits with one other trained observer before collecting data on their own. The main practice leadership observer had been involved since the start of the project and had collected data in each stage of the measure's development.She already good reliability established with both the first and second authors. The second observer conducted a number of observations with both the third author and the first observer and had showed good reliability. A random selection of the ratings for this observer were also checked by the first author and no issues were identified. The first author listened to all the

audio recordings of front-line manager interviews and read the field notes to check all the ratings of the third observer, who was less experienced in terms of practice leadership.

Ethical considerations

This study was conducted in Australia in accordance with the Australian National Health and Medical Research Council Ethical Guidelines (2007). Ethical approval was gained from the University Human Ethics Committee. Consent was gained from both staff and from or on behalf of service users. Where a person was judged not to be able to give informed consent, their next of kin, guardian or the person who usually made decisions on their behalf was asked to agree to their participation. This was usually the case for those with more severe disabilities (just over half the sample). However assent was checked during the visit both directly with service users where possible to ask them but also by observations, which were stopped if the individual being observed showed discomfort with being observed. Observations only happened in services where enough staff consented to make the shift viable and where it was possible to observe service users who did consent without upsetting those who did not.

Data analysis

Measures of reliability included Cronbach's Alpha for internal consistency and Kappa, Spearman Rho and total percentage agreement for inter-rater reliability. As some measures were collected at service user level and some at service level, analysis was undertaken at both levels. At service user level, the analysis explored whether living in a service where staff received better practice leadership resulted in better support from staff and better outcomes – as such where more than one service user took part in the study (most services) the same practice leadership score was used for each person. Some key analyses were also conducted at service level to see if the effects were also found in the smaller

sample. In addition cluster analysis was used to look at how data on the practice leadership measure were clustered.

Findings

Internal consistency for the Observed Measure of Practice Leadership measure was high (Cronbach Alpha = 0.907). As such an overall score was computed across the five domains. The correlations between each domain are presented in Table 1. Although, as Table 2 shows, there was substantial variability between the services in terms of ratings, there was in general good consistency across the items of the scale. When a service scored higher on one item they tended to score higher on the other domains.

Insert Table 1 about here

Two-step cluster analysis identified three clusters from the 5 domains with a Silhouette measure of cohesion and separation which fell right on the borderline between Fair and Good (0.5). Exploration of the data identified that the variable which best explained these clusters appeared to be overall percentage score on the practice leadership measure. Cluster 1 equated with an overall score of between 0 and 20, Cluster 2 between 20 and 55 and Cluster 3 over 55. If service identifier was included in the cluster analysis this slightly improved the cohesion and separation to just above 0.5 but reduced the number of clusters to just 2. Here one cluster appeared to equate to an overall percentage score 55 and above and the other to a percentage score below 55.

Quality of practice leadership, active support and levels of engagement.

Insert Table 2 about here

Table 2 illustrates substantial variation both in the quality of practice leadership and in levels of active support. Overall levels of active support were mixed, good pockets were

found in most organisations with one showing higher levels. Overall, practice leadership was poor but in one organisation and in a few other isolated services, it was rated more highly.

Relationships between practice leadership and the quality of support

Insert Table 3 about here

Positive correlations were found between active support and level of adaptive functioning (Spearman's rho = 0.624, $p<0.001$, n = 173), and between assistance and level of adaptive functioning (Spearman's rho = 0.199, $p<0.01$, n = 171) and a negative relationship between the score on the Practice leadership item on coaching and level of adaptive functioning (Spearman's rho = -0.249, $p=0.001$, n = 186). Service users with more severe impairments received less assistance and weaker active support than more able service users and tended to live in services where the front-line manager provided at least some form of informal coaching or modelling to staff. When active support is well implemented then the correlation between ability and active support should disappear as people receive just the right type of support. However, those with more severe impairment should generally receive more support than those who have higher levels of skills.

As such, partial correlations controlling for adaptive behaviour were conducted between ratings on each of the practice leadership domains, measures of quality of support (ASM and percentage of time receiving contact from staff) and levels of engagement. Table 3 presents the results from the correlation analysis conducted at service user level and also at service level. There were some positive significant correlations, in particular between the ASM and practice leadership. When conducted at service user level (using a service level mean on each of the practice leadership domains for each service user) there were significant positive correlations between mean practice leadership scores overall and on all 5 domains and active support. The strongest relationship was with the coaching domain. There were also

significant positive correlations between the amount of time people received contact from staff (other than assistance) and overall practice leadership score for the service and for domains of allocating staff, coaching and supervision. Finally there were significant positive relationships between the quality of practice leadership in a service (overall and on all domains apart from coaching) and the amount of time each service user spent engaged in any form of meaningful activity.

At the service level, using a service average for engagement, active support, assistance and contact (n=46), there were even stronger correlations between active support and practice leadership and again the strongest correlation was for the coaching domain. Correlations between practice leadership and the amount of contact people received from staff (other than assistance) were also significant overall and for allocation of staff, coaching and supervision. At this level there were no significant relationships with engagement.

There were no significant correlations between the score on practice leadership and the amount of assistance people received at either level of analysis.

Does the measure differentiate high levels of active support and better outcomes for individuals?

At the service level only 5 services were rated 3.5 or above on average across all 5 on domains of the practice leadership measure. As such a less stringent rating of practice leadership was adopted and the data recoded into a mean score of 3 and above (n=12) and below 3 (n=34). Data did not meet parametric assumptions and so Mann-Whitney U tests were conducted and confirmed the correlation analysis presented earlier. Services where practice leadership was better, provided significantly better active support ($z = 2.540$ $p = 0.01$, $n = 46$). There were no difference on the other domains and no significant difference with regard to adaptive behaviour.

At the service user level, those who were more able tended to live in services where practice leadership was higher overall but the difference here was not statistically significant. Active support was significantly better in services where practice leadership overall was better and service users were also more engaged (See Table 4).

Insert tables 4 and 5 about here

Exploring further the two groups identified in the cluster analysis confirmed the links between the two variables – those who were in the higher practice leadership group identified by the cluster analysis were significantly more likely to be receiving consistently good active support (a score of 66.67% and above on the ASM; chi-square = 11.872, p=0.03, df 2, n=167).

At the level of individual items on the practice leadership scale, there are some interesting findings (see Table 5). Active support is significantly better for people who are living in services where the score on allocation of staff ($t(171) = 3.60$, $p < .0001$), team meetings ($t(171) = 3.73$, $p < .0001$) and front-line manager overall focus on quality of life ($t(171) = 2.54$, $p < .01$) is higher. However for allocating staff, there is an interaction with level of ability – service users in services where better systems exist for allocation of staff to meet needs and maximise engagement were generally more able ($t(187) = 2.82$, $p < .005$). This probably at least partially explains the significantly higher levels of engagement too ($t(169) = 4.6$, $p < .0001$). For the domain of coaching, services users in a service where coaching is better tend to be engaged less ($t(169) = -2.71$, $p < .001$) but this is likely to be explained by significantly lower levels of adaptive behaviour for these individuals ($t(187) = -4.57$, $p < .0001$). When team meetings are in place and at least used to review service user needs and quality of life, levels of engagement are higher ($t(169) = 2.62$, $p < .01$).

Discussion

This study tested the validity and reliability of the Observed Measure of Practice Leadership and described the links between practice leadership, quality of support and quality of life of people with intellectual disabilities. The measure was found to have good internal consistency, inter-rater reliability and construct validity in that it appears to discriminate well between services on the quality of staff practice and in some domains also discriminates in terms of outcomes for services users. As hypothesised by Beadle-Brown et al. (2013), when practice leadership is better, then active support appears to be better implemented and engagement is higher. Regarding the measure itself, there are a number of limitation that need to be acknowledged. Test-retest reliability was not measured in this study as the data was collected as part of a larger study and sending observers in more than twice during each round of data collection would have been too intrusive. As in Beadle-Brown et al. (2013), the study found generally low levels of practice leadership, which is line with the generally weak to mixed active support found in services in Australia and the UK (Mansell et al ., 2013; Mansell & Beadle-Brown, 2012, chapter 2). In order to fully test the reliability and validity of the measure it is necessary to conduct research in a sample that includes more services that are providing consistently good support for the majority of people supported which was only the case for one third of individuals and services in this study. This would allow further investigation of the psychometric properties of the measure including test-retest reliability and factor analysis. The other difficulty in the current study was identifying the position or person that was primarily responsible for practice leadership given the different organisational models. These included responsibility resting with: front-line managers; the manager of the front-line manager; a specialist position with no direct line management responsibility for staff; and a mixture of the latter two. The impact of different models on the quality of leadership, the staff practice and outcomes for those supported, is being explored in

another study by the authors. The larger project from which this data was drawn will explore the effect of the different models of practice leadership used in different organisations.

The main limiting factor in regard to ease of using the measure was lack of organisation within services – or the level of chaos. Despite front-line managers having been asked to be present during the observations, in some cases they were not – leaving the service immediately after the interview. Due to high staff turnover, some front-line managers had only just started the job or were acting in the position and found the questions difficult to answer. Low staff service user ratios meant it was often difficult to talk even briefly to other staff, and some were reluctant to do so when the front-line manager was present.

The capacity of the Observed Measure of Practice Leadership to differentiate quality of support and outcomes does not appear to extend to all of the outcomes across all the domains. However, it is possible that some domains of practice leadership are more important for some outcomes than for others. For example, active support was better when the practice leader organised the staff team better, when team meetings were held and focused on quality of life and supporting residents and when the front-line managers overall focus was the quality of life of the people supported. However, contact between staff and service users was greater when coaching was better. The r values of the correlations co-efficients, although significant, were relatively low but this is likely to be due to the generally low levels of practice leadership, with only 5 services having good to excellent practice leadership overall. There were also relatively low levels of active support, assistance and a tendency for things to be better for those who were more able, all of which could be confounding the relationships between practice leadership and the other variables.

Ensuring reliability on observational measures, such as those used in this study, is not straightforward. It is important for observers to be very familiar and confident with the concepts they were measuring in practice – in particular it helped for them to see what good

active support looked like and to identify examples of good practice leadership. It is, however, possible to train non experts in active support and practice leadership to conduct these observations to reliability once observers have a solid understanding of the concepts and have seen examples of them in practice at both ends of the scales. It is anticipated that this measure will be useful for researchers exploring the factors affecting quality of services and the experiences of service users. It will have potential value for quality assurance processes and service development for organisations that are trying to effect change in staff practices.

However, although important in terms of collecting the data for this study, these factors are also all important in thinking about the quality of staff support and the outcomes achieved for the individuals supported. As noted above, the quality of support in these services was relatively mixed, with only one third of people receiving good consistent active support and one third of people receiving weak active support. As a result levels of engagement were also lower with people on average spending less than 50% of their time engaged in meaningful activities and relationships but with substantial variation – some people were not engaged at all and some people were engaged throughout the observations. This was in general related to client level of ability – those who were more able were more engaged, usually without any staff help. Almost two thirds of people received no facilitative assistance from staff to be engaged.

Further research could usefully explore the use of the measure in different contexts, used by different people, establishing reliability and ease of use. It could also explore the impact on other staff practices such as communication strategies, positive behaviour support and the impact on staff culture more generally. Finally, future research should start to look at the factors (including individual characteristics, training and supervision and support from senior managers) that support front-line managers to be good practice leaders. In order to do

this, it may be necessary to actually develop a training programme for practice leaders and then to implement that training comparing those that go on to implement practice leadership well in terms of those that do not in terms of individual characteristics of staff, support and supervision from senior managers as well as observing the impact of practice leadership. Such a training resource is currently being developed and will be used in future research.

Finally, even though further research is needed, these findings have implications for policy and practice, in particular the training and support for front-line leaders in services for people with intellectual disabilities. This is particularly true in the context of changing roles of staff in services to be more active and facilitative, to be less service based, more person-centred and more community based, more enabling and empowering (Lakin and Stancliffe, 2007; Reinders, 2008; Schalock and Alonso, 2012, Mansell and Beadle-Brown, 2012). Currently in the UK and Australia, practice leadership and in particular coaching, is not part of general training for those running services. Even if it was, it would not be enough for managers to just learn about the mechanics of coaching – they also need to be skilled practitioners in the type of support they want to encourage in their staff. This has implications for the recruitment, training and development of those who are leading staff teams. Those providing training and support for front-line managers need to have a clear (shared) account of what person-centred support looks like, something that currently is missing from policy and practice in most countries. In the UK for example, person-centred support is equated in policy with person-centred planning and much less with person-centred active support – i.e. the minute by minute enabling support that staff provide people to be involved in every aspect of their own lives (Mansell & Beadle-Brown, 2014). Although recently use of positive behaviour support to work with those with challenging behaviour has

been emphasised, the significance of active support is still very much excluded from most official discussions, despite it being one of the single most researched approaches to supporting adults with intellectual disabilities and achieving good outcomes. Finally, agencies that set competencies for staff and managers in the social care sector need to engage with the issue of active support and with the concept of practice leadership, not just leadership and management. Registration agencies also have a role to play here in ensuring that those who manage services have good awareness and experience of working with good practices.

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Table 1: Observed practice leadership inter-item correlations at service level (n=46 ** = p<0.01)

	PL Coaching staff Score	**PL Supervision Score**	**PL Team Meeting Score**	**PL Manager Focus Score**	**PL Mean score**
Allocation of staff	.679**	.571**	.627**	.639**	.837**
Coaching		.608**	.657**	.690**	.878**
Supervision			.535**	.627**	.781**
Team Meetings				.593**	.785**
Overall focus on QOL					.827**

Table 2: Descriptives statistics for the observed practice leadership measure and the active support and engagement measures

Practice leadership				
	Mean (SD)	Range	Median	Percentage of services rated as good or excellent (score of 4 or 5)
Allocating staff	2.43 (1.2)	1-5	2	17%
Coaching staff	2.33 (1.14)	1-5	2	11%
Supervision	2.30 (1.03)	1-5	2	11%
Team meetings	2.80 (1.0)	1-5	3	22%
Focus on QoL	2.61 (1.02)	1-5	3	20%
Mean score	2.50 (0.92)	1-5	2.4	11%
Total score	12.2 (4.5)	5-25		
Overall percentage score (max 25)	36% (22.5)	0 – 100		
Quality of support and outcomes				
Active support score (%)	50 (25)	2 – 97		
Percentage of time receiving assistance	3 (6)	0 – 28		
Percentage of people receiving NO assistance to be engaged	65%			
Percentage of time engaged	47 (31)	0 – 100		

Table 3: Correlations between practice leadership measure and measures of engagement and quality of staff support.

	Any engagement	**Active Support measure**	**Assistance from staff**	**Other Contact from staff**
At service user level (n=166)				
Allocating Staff	0.208**	0.222**	0.01	0.229**
Coaching	0.100	0.363**	0.055	0.203**
Supervision	0.157*	0.214**	0.017	0.175*
Team meetings	0.245**	0.315**	0.046	0.115
Focus on QOL	0.197**	0.336**	0.044	0.131
Mean PL score	0.212**	0.338**	0.039	0.201**
At service level (n=43)				
Allocating Staff	0.192	0.36*	0.176	0.355*
Coaching	0.127	0.504**	0.215	0.375*
Supervision	0.117	0.332*	0.139	0.317*
Team meetings	0.255	0.411**	0.192	0.175
Focus on QOL	0.178	0.474**	0.242	0.243
Mean PL score	0.201	0.484**	0.224	0.345*

* = $p < 0.05$ ** = $p < 0.01$

Table 4: Comparing quality of staff support received, engagement and client characteristics in the context of high and low practice leadership.

	Mean scores when PL weak (below 3) n=143 (SD)	**Mean scores when PL higher (3 and above) n = 46**	**Significance**
Active Support % score	46% (24.1)	63% (25.5)	t(171) =3.88 ***
% time receiving Assistance	3% (5.0)	4% (6.9)	Not. Sig.
% time receiving other contact from staff	16% (16.4)	20% (18.5)	Not. Sig.
% time Social activity	13% (19.0)	20% (21.1)	z = -2.159 *
% time Non- social activity	33% (27.1)	44% (31)	z = -2.001 *
Any engagement	44% (31.8)	59% (28)	t(169) =2.63 **
ABS Part 1 score	135 (66)	151 (66)	Not. Sig.
Age (in years)	42 (13.6)	43 (12.4)	Not. Sig.
ABC score	24 (33.3)	26.5 (22.8)	Not. Sig.

* = p< 0.05 ** = p< 0.01 *** = p< 0.001

Table 5: Mean score on each service user level variable by weak (Score below 3) and stronger practice leadership (score 3 and above) on each of the individual domains. Shaded cells with figures in bold and italics indicate significant differences on the Mann-Whitney U test between weak and stronger practice leadership

	Allocating staff		Coaching		Supervision		Team meetings		Manager focus	
	Weak PL N=121	Better PL N=68	Weak PL N=115	Better PL N=74	Weak PL N=107	Better PL N=82	Weak PL N=85	Better PL N=104	Weak PL N=89	Better PL N=100
% score on Active support	**4**	**8**	9	0	7	3	**2**	**6**	**5**	**4**
% time receiving assistance										
% time with other contact	6	9	**5**	**0**	**5**	**0**	6	8	5	9
% time Any engagement	**9**	**1**	**2**	**9**	5	0	**1**	**3**	6	9
Total score on ABS Part 1	**29**	**57**	**56**	**13**	41	36	37	41	45	34
Mean Age	2	3	3	2	3	1	2	2	3	1
Mean score on ABC	4	7	5	6	6	4	4	6	4	6

Appendix 1: The Observational Practice Leadership Measure and examples of coding on each domain.

The measure

1) Allocating and organising staff to deliver support when and how service users need and want it	☐
Evidence/rationale for rating	
2) Coaching staff to deliver better support by watching how staff support people, telling them what they are doing well and what needs to be improved and showing people how to provide better support.	☐
Evidence/rationale for rating	
3) Reviewing the quality of support provided by individual staff in regular one-to-one supervision and findings ways to help staff improve their support	☐
Evidence/rationale for rating	
4) Reviewing how well the staff team is enabling people to engage in meaningful activity and relationships in regular team meetings and finding ways to improve it.	☐
Evidence/rationale for rating	
5) The manager/house supervisor focuses, in all aspects of their work as manager, on the quality of life of service users and how well staff support this	☐
Evidence/rationale for rating	

1=Very weak (approaches non-existent; Could do a much better job than this)

2=Weak (Poor performance; could be improved)

3=Mixed (Some good points but weak points too)

4=Good (Many strong points, consistent good performance)

5=Excellent (Outstanding, hard to do better than this)

1.1 Allocating and organising staff to deliver support when and how service users need and want it

Rating	What it would look like
1	No planning system at all (or a plan which is out of date or which no one appears to look at and what happens in reality bears no resemblance to the piece of paper) - staff just do what they want and the users' needs are not taken into account at all.
2	A plan exists so that staff tasks are allocated but this is not tailored to the service users' needs or activities, only changing to suit staff needs (e.g. Mary doesn't want to go swimming today so refuses to take Jack and Fred). Changes not well communicated to service users and it is clear that the plan is staff centred, not person-centred.
3	There is a plan for the day which appears to be different for each individual and each day and is based around the activities of the service users. However, staff are not allocated to particular tasks or even people at different points in the day and so confusion can sometimes arise and some tasks are missed or staff stick to the plan rigidly, missing opportunities to involve people and not responding to the needs or requests from individuals as they arise (e.g. I'm sorry John, we can't start dinner yet, it isn't time. When the clock says 5 o'clock we can start).
4	There is at least a basic plan for the day/shift where staff know the main activities people will do (usually external/structured) and know what their basic tasks are (e.g. who will book the taxis, who will go with John to the day centre, who will take Mary shopping) and they may allocate other tasks as they go (Natasha, you help John do the laundry while I help Fred put the shopping away). However, some opportunities are missed and people sometimes "get lost" between activities or wait a long time between activities as staff are primarily focusing on the next planned activity (or are having a break). Some evidence of flexibility but this might sometimes be to suit staff as well as individuals being supported. More flexible and responsive to the needs of service users with clearer staff responsibilities/allocation than in 3 but a new member of staff or agency staff might struggle to work out what they should do and when. Although some flexibility is evident some opportunities to involve people still are missed.
5	There is plan for the day which is specific to the people living in that house, which tells staff and the people they support who will be supporting which person in which planned activities during the day. This is detailed enough so that staff know what they are responsible for. Plan is also available in accessible form for service users and there is evidence of flexibility. You see staff taking opportunities not on the plan to involve people and you see (or have examples of) staff responding to the requests or needs of the individuals and changing the plan. Service user preferences are prioritised.

1.2 Coaching staff to deliver better support by watching how staff support people, telling them what they are doing well and what needs to be improved and showing people how to provide better support.

Rating	What it would look like
1	No evidence that the manager spends any time coaching or modelling. He/she is never out of the office and when on shift works alone. You might see not very good practice if the manager is supporting. Staff are doing things that they shouldn't be doing and manager is not noticing or is noticing, complaining to you about but not giving feedback to staff.
2	Manager says that they spend time informally watching staff but can't give very good examples of how he/she has used that information to try to shape up performance. Their own practice if observed is ok but they don't correct or support other staff. They might say they talk about good practice in team meetings etc. and give some examples but there is no sense that they model or coach staff in any way, even on an adhoc basis.
3	Manager does not spend time formally observing but can give examples of how they have spotted things while walking about or working on shift and then used that information to give feedback to staff, feed into supervision etc. No use of role play or videos in team meetings but do discuss the support for individuals. Their practice is quite good but they can't give good examples of how they have modelled for a particular staff or activity. Or they can give some examples but which are about things other than active support or engagement – e.g. how to use a particular piece of equipment or how to give medicine etc.
4	Manager spends some time in formal observation and giving feedback and is seen to provide modelling or coaching (or gives a good account of how he/she has done this). However, opportunities for this are left somewhat to chance and there is no system in place where manager/supervisor spends time regularly with each member of staff. So who receives modelling will depend on who the manager is on shift with etc.
5	You observe or manager gives examples of how he/she regularly observes and works with staff. There is a system of some sort in place to ensure that all staff are observed and receive feedback on a regular basis and manager can give good examples of how he/she has done this. Example shows that they are focusing on active support.

1.3 Reviewing the quality of support provided by individual staff in regular one-to-one supervision and finding ways to help staff improve their support

Rating	What it would look like
1	No formal system of supervision or appraisal in place and no informal supervision.
2	Some supervision or appraisal in place but it is not regular or only annually and/or it does not focus on active support, or if it does it only focuses on it in a disciplinary context.
3	Organisation has a formal system and recommended frequency but this is currently not yet happening in the service. However manager does meet informally with people when he/she can and gives them some feedback. This is not just focused on disciplinary issues, paperwork etc.
4	Most staff have regular supervision but some staff don't or it is at a slightly less frequency than organisations suggest.
5	All staff have regular supervision (e.g. once every month or six weeks) which focuses primarily on active support, provides feedback and an opportunity for staff to ask their supervisor for help and advice around supporting individuals.

1.4 Reviewing how well the staff team is enabling people to engage in meaningful activity and relationships in regular team meetings and finding ways to improve it.

Rating	What it would look like
1	No regular team meetings or no other forum for reviewing situation for each service user.
2	There are some team meetings but these focus on something other than the quality of life of the people supported – e.g. on staff issues, health and safety/workforce safety.
3	Some team meetings but not regular and not all staff attend but the focus is on user issues. Or regular meetings focusing on individuals but the focus is primarily on the behaviour of the individuals rather than on engagement and on what staff can do to support people better.
4	Regular team meetings, with an agreed proforma, which most or all staff attend, which includes a review for each service user around what they are doing but it isn't clear what the discussion has focused on an whether team performance is discussed. Manager or staff haven't provided examples and no minutes kept (or not yet written up) so that the discussions can feed into other processes.
5	Regular team meetings with an agreed proforma which all staff attend. This provides feedback on team performance in supporting people in activities. Team meetings are used to solve problems with regards to supporting people to be involved in their lives, to ensure consistency of approach etc. Minutes are kept so that the discussions are recorded and then used to feed into e.g. support profiles or person-centred plans.

1.5 Focusing, in all aspects of their work as manager, on the quality of life of service users and how well staff support this

Rating	What it would look like
1	Manager clearly prioritises paperwork and admin, they talk mainly about keeping the house running, doing rosters, don't mention helping staff to do a good job, ensuring good practice etc. No evidence that active support is in place and that people are engaged. No clear account of why the home is there. If they mention active support they have clearly misunderstood what it is.
2	The manager expresses that the home is there to support people, care for people, keep people safe and some evidence that the people come first but when under pressure the manager prioritises other things. Little evidence that active support is happening and that people are engaged. There is at least evidence that the manager has misunderstood some of the principles of active support. Might say they coach but it is clear that either this doesn't happen or that it is focused only on things like giving medications.
3	This is usually a mixture between a rating of 2 and 4 – so for example manager clearly expresses that this is the most important and people are engaged at least part of the time although staff may not be doing much to help them. The manager doesn't pick up any issues. Meeting minutes have user issues discussed but may not be first issue discussed or may be focused on health and safety and not engagement, inclusion etc. Team meetings not used to shape up how staff support individuals. Or they are sometimes but not very often. The manager may be very clearly motivated by the needs and quality of life of individuals but not skilled or even clear about how to achieve it – they might mention active support but what they say might indicate that they don't quite understand what it is and how to implement it.
4	The manager clearly expresses that the house is about promoting quality of life, independence, inclusion etc. and that this is the most important part of their job and that of the staff. They give some evidence that they prioritise user quality of life (not just health and safety) over admin and similar tasks. They mention that their job is about ensuring staff do a good job with people and talk a bit about coaching or observing and giving feedback to shape performance but this is ad hoc and mainly informal. People are engaged and you see staff providing good support and managers recognising this etc. In essence most things are in place for practice leadership but one or two small things might not be quite there (perhaps no formal coaching or some small misunderstanding of active support principles).
5	Couldn't be any better. The manager clearly expresses that the house is about promoting quality of life, independence, inclusion etc. People are engaged with good quality staff support. Active support is well embedded and staff clearly identify the manager as focusing on the quality of life of people. Evidence that the manger shapes staff behaviour both formally and informally. People supported and the quality of support staff give are the main and first topic of discussion of meetings.