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**An interpretive phenomenological study exploring
the experiences of extended scope physiotherapists.**

**Does viewing them as institutional entrepreneurs
engaged in institutional work provide an
understanding of these experiences?**

Peter Creegan

A thesis submitted to the University of Huddersfield in partial fulfilment of the
requirements for the degree of Doctor of Physiotherapy.

The University of Huddersfield

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Abstract

Objectives: To understand the experiences of physiotherapists as Extended Scope Practitioners (ESPs) working in acute NHS hospitals using the concepts of Institutional Entrepreneurs engaged in Institutional Work.

Design: A qualitative study using an interpretative phenomenological framework.

Methods: In depth, semi-structured interviews which were analysed thematically using the steps suggested by Van Manen (1992). Themes which emerged represented the experiences of all the participants. Once the themes were identified the concepts of Institutional Entrepreneurs and Institutional work were applied to provide an understanding of the ESPs' experiences.

Participants: 12 ESPs from three acute hospitals from a variety of clinical specialties (2 gynaecology, 3 neurology, 2 orthopaedics, 2 paediatrics, 1 pain management, 1 cardiology, 1 respiratory).

Results: The first theme identified the motivation of the participants to extend their remit and create opportunities for the new role. The impact of this, for some participants, was a confused professional identity not aligned with physiotherapy. They felt different to physiotherapists in the way they thought clinically and their methods of practice. This manifested itself in their refusal to wear a uniform. The second theme explored negotiation and agreements of clinical boundaries between the participants, consultants, managers and other clinical staff. The ESPs were proactive and astute basing their actions on both a professional and business logic. They knew when to propose or create an opportunity, when to consider alternatives and when not to act based on the professional relationships with other professions, NHS pressures or likelihood of success. The final theme identified the adaptive nature of ESP roles. The participants were sensitive, and felt vulnerable, to NHS change. They voiced concerns over the sustainability of such posts in terms of succession planning and a lack of framework to develop such roles in the future.

Using the typography of Institutional Work provided an understanding of the ESPs' experiences. It identified successful and less successful types of work and enabled discussion on what can be achieved at the micro, individual level, what needs input from the macro, profession level and how the two can support each other. It also identified weaknesses to be addressed that would benefit the professions development.

Conclusion: The results from this study address the dearth of literature on the experiences of ESPs and provides details which will have resonance with physiotherapists and insight for other professions. It is recommended that a more robust ESP professional network, to champion and diffuse new practice into the NHS, is needed. Secondly there is a need for a recognised and nationally validated education programme for extended practice. This study refines the institutional work concept and highlights the inter-relationships between diverse types of work. It challenges the assertion of a sequential order of institutional work and illustrates how individuals embedded in the institutions of the NHS and physiotherapy can stimulate change through strands of institutional work that are sympathetic to the workplace environment and culture. This study provides empirical evidence that institutional work is performed by ordinary individuals which can diffuse through a profession. In doing so it provides insight for physiotherapists and other professions as to ways and means this can be achieved.

Keywords: ESP, extended roles, experiences, institutional entrepreneurs and institutional work.

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Chapter One: Introduction

1.1 Overview

This study explores the experiences of physiotherapists extending their scope of clinical practice to take on tasks previously undertaken by medical practitioners. The Chartered Society of Physiotherapy (CSP), the physiotherapy professional body, in its vision for the future, identified Extended Scope Practitioners (ESPs) as one of the ways physiotherapy could meet the changing needs, demands and opportunities of UK healthcare (CSP 2010). There is a paucity of literature on the experiences of physiotherapists engaged in creating and developing these roles. This study provides detailed insight, from several physiotherapists, in a variety of clinical settings, into their experiences of creating and establishing ESP roles in acute hospitals.

The study takes an interpretative phenomenological approach, using semi-structured interviews, to capture the voices of the participants as they describe the creation and development of their role. Their ambitions, motivation, pathways, successes and failures are explored as they describe their journeys to become established ESPs. For some, this was still an on-going process but for others it was the realisation of an ambition. The experiences of the participants were intricately linked with changes in the NHS and the responses of other professions and managers to those changes. To understand these experiences this study argues that professions can be viewed as institutions which Hodgson (2006) describes as systems of established and prevalent social rules that structure social interaction. Institutions enable ordered thoughts, expectations and actions by imposing form and consistence in human activity (Scott 2001) and provide the standards and behaviours required for legitimacy within an environment through socially constructed rules and routines which establish a sense of meaning (Zietsma and McKnight 2010). These structures create a logic for the institution and instruction on how to interpret organisational reality and how to behave and succeed (Fredriksson et al 2013). However, these logics can act and are acted upon by political, legal,

technological, economic and social forces and the individual or individuals within a profession (Lawrence and Suddaby 2006). Change can occur internally within a profession and externally in the relationship that a profession may have with other professions.

Physiotherapy is the third largest group of health care professionals in the UK (Richardson et al 2015) as well as the third largest profession in the healthcare sector throughout the world (Ottosson 2016). Physiotherapists are socialised into a profession with changing attitudes, beliefs, motivations and values (Sparkes 2002) and this evolving career, and changes in clinical practice and role, impacts on the identity of a profession and how it is perceived by others (Hammond 2016). In other words, individual practitioners or collectives can create change in a profession. Di Maggio (1988 p14) introduced the notion of institutional entrepreneurship in that “new institutions arise when organised actors with sufficient resources see in them an opportunity to realise interests that they value highly.” This idea of an actor can be applied to a large organisation or the state but it can also include individuals. Lawrence and Suddaby (2006 p215) introduced the concept of institutional work which they defined as, “purposive actions..... aimed at creating, maintaining and disrupting institutions.” Institutional work, they argue, can be applied to various levels of institutions from the global companies, to professional organisations and to individuals in an organisational field engaged in change. Considering the participants as institutional entrepreneurs engaged in institutional work provides a means of understanding their experiences of being an ESP.

The aim of the study was to capture the experiences of ESPs and understand them using the conceptual framework of institutional work. This study therefore contributes to current knowledge and understanding through the following objectives.

First it adds to the published work on the experiences of ESPs and provides through the participants` voices aspects of the role for others to consider. It does this by:

- Providing an insight into the process of change and includes examples of successes and setbacks.

- It identifies the purposeful action of the participants engaged in the process of creating these roles and the work involved in maintaining and sustaining them.
- It describes the relationships that develop between health professions as clinical boundaries are redefined in the workplace.

Secondly, institutional work remains detached from the everyday occupational tasks and activities in the workplace (Kaghan and Lounsbury 2011). This has resulted in a call for future studies to bring the individual back into the study of institutional theory by examining the experiences and activities that occur in the organisation as types of work (Marti and Mair 2010, Lawrence et al 2011, Smet and Jarzabkowski 2013, Bevirt and Suddaby 2015). This study addresses this criticism by placing the individual at the centre of the study.

- It considers the experiences of the ESPs using the typology of institutional work. In doing so the nuances of the institutional work are evaluated from the individuals' perspectives.
- Further, by using institutional work to understand the participants' experiences it shifts the understanding to how actors affect institutions rather than how institutions affect the individuals. It provides detail on how individuals embedded in an organisation negotiate and reconcile competing world views and bring about change within an institution.

Thirdly, much of the research of institutional work that includes the individual tends to emphasise powerful actors with a strong bias towards prominent and successful entrepreneurs with abundant resources (Smets and Jerzabkowski 2013).

- This study addresses some of these concerns by focusing on individuals who are not in a powerful position within the organisation. It uncovers how physiotherapists engage in changing roles and the ways and means they achieved this.

Fourthly, the role of the CSP, as the professional body, is considered.

- The institutional work of the CSP is identified and areas are highlighted where the profession could engage in institutional work to maintain current ESP roles and make the creation of such posts easier to achieve.
- In doing so it answers Kaghan and Lounsbury (2011 p75) call to “re-connect the macro-worlds of institutions and the micro-worlds of the actors who populate them.”

This study describes the experiences of physiotherapists involved in professional change and provides an understanding of those experiences in terms of institutional work. It captures the processes, successes and failures, illustrates how professions adapt in response to external changes and the motivation and action of its members.

1.2 Structure to the thesis

Each chapter provides a step wise progression through the thesis leading to a conclusion. Chapter two provides the background and historical perspective to the study in terms of national policy changes in the NHS and the responses from healthcare professions including the developments of ESPs. These changes, and the development of professions, are briefly examined within the context of the sociology of professions before introducing the concepts of institutional entrepreneurs and institutional work. Chapter three outlines the current literature on the experiences of being an ESP before evaluating studies which have used institutional work to understand the endeavours of individuals engaged in institutional change. It is argued that institutional work provides the means to understand the “lived experiences” of the participants.

Chapter four outlines the methodology of the thesis and the reasons for and criticisms of choosing an interpretative phenomenological approach. Chapter five details the method beginning with ethical approval, recruitment of participants, interviews and analysis of the data. It describes the challenges encountered and the ways in which these were resolved. Chapter six describes, and begins the interpretation, of the themes and sub themes which emerged

from the analysis using the words of the participants. Chapter seven, in the discussion, argues that the ESPs can be considered institutional entrepreneurs. They created and developed the opportunity with others to sustain the role through institutional work. The types of work undertaken by the participants are identified and discussed in terms of successes and challenges faced. Finally, this chapter discusses the interface between the CSP and the individual, drawing out the common threads that could be enhanced. Chapter eight reviews the outcome of the study and the contribution to greater understanding of the ESPs' experiences. In doing so the aim and four objectives outlined in the overview (p10-11) are revisited and discussed. Chapter nine draws the thesis to a close outlining its contribution to new knowledge and understanding. It identifies the limitations to the study but also makes further recommendations.

Implicit within the philosophical basis of interpretative phenomenology is an acceptance that the researcher is not separated from the world and are implicated in the research process (Finlay 2006). The argument is, that to fully comprehend the lived experience the researcher needs to accept that they are part of the process and use this to add contextual interpretation and meaning (Willig 2004). This should be an explicit part of the process to allow the reader to draw their own conclusions as to the credibility of the research (Langdrige 2007). This openness with the reader is demonstrated by reflexivity, which is described as, "the capacity to reflect on one's actions and values during the research, and when writing accounts, so that one's beliefs can be viewed in the same way as those of the participants" (Arber 2006 p147). In chapter four (pg48) reflexivity is discussed but in highlighting it here it presents the opportunity to describe its place in the structure of the thesis.

Longhofer and Floersch (2012) argue that in qualitative research there is a need to establish trustworthiness in the study. Reflexivity can be understood as the process through which the researcher establishes and articulates the basis for that trust (Probst and Berenson 2014). So, throughout the thesis there are reflexive sections that consider the processes and changes in the researcher's perspective that occurred during the research. These reflexive processes

were recorded in a diary, examples of which are attached in the appendix. Van Manen (1992) suggested that one way to engage with the reader and begin the process of building trust in the research process and outcome, is to introduce the researcher and explain the reasons for doing the research. In that way transparency, can be created in which the reader can assess the credibility of the person engaged in the research. In these reflexive passages, there is a change in voice from the third person to the first person.

1.3 Reflexivity

This is not a process that I find naturally easy or comfortable to engage in, but I accept the need for transparency in this interpretative phenomenological investigation. Like other novice researchers it was a process and skill that developed during the research journey (Walker et al 2013; Grant 2014). To briefly introduce myself, I was at the beginning of the study head of physiotherapy in a large NHS acute hospitals trust. I had been a practising physiotherapist for over twenty years and had worked in several clinical areas. I was always fascinated by how physiotherapy seemed to develop in new clinical areas and embrace new clinical skills and roles. Such adaptations at the time included: peripheral joint injections for musculoskeletal conditions (Aitkins 2004); diagnostic ultrasound (McKiernan et al 2010); as well as new roles in accident and emergency departments (Annaf and Sheppard 2007) and direct patient referral and access to physiotherapy (Holdsworth et al 2008).

The aim of physiotherapy is to promote, maintain and restore the physical, social and psychological well-being of individuals using physical approaches to human movement and function (CSP 2002). Physiotherapists are registered by their own professional organisation, the Chartered Society of Physiotherapy (CSP) and regulated within the UK by the Health and Care Professions Council (HCPC). Since 1923 Physiotherapy has had a Royal Charter which outlines four key areas of clinical practice. These four pillars of practice as they became known were; massage, exercise, electrotherapy and “kindred forms of treatment” (CSP 2008 pg4).

The first three relate to specific treatment but the fourth has been used to extend physiotherapy skills and roles. This fourth pillar led Parry (1995 p310) to describe physiotherapy as “whatever physiotherapists do within their bounds of professional liability”. This can be illustrated with the incorporation of complementary clinical skills into physiotherapy practice. Physiotherapists have now become the predominant practitioners of acupuncture in the NHS and private practice (Hehir and Williams 2012). Other recent examples include Pilates (Gracey et al 2015) and Reflex Therapy (which is akin to reflexology) described as “a non-invasive physiotherapy modality approved in the UK by the CSP” (Berry and Svarouska 2014 p1).

Building on the fourth pillar the CSP confirmed that, within certain limits, such as the law, if a proposed intervention can be considered a physical means to address the physical and cognitive needs of the patient, and that the physiotherapist is satisfied that they are appropriately trained and competent, then it falls within the scope of physiotherapy (CSP 2008). The reasoning behind this policy was based on the premise that practice is a dynamic process and to define boundaries would stifle innovation and make the profession less adaptable to change. Individual physiotherapists were still subject to the rules of professional conduct (CSP 2002) which restrict practice to achieved and demonstrable competencies and to the standards of conduct performance and ethics (HCPC 2004) and the standards of proficiency (HCPC 2007) as laid down by the national regulatory body. So, a physiotherapist could take on new clinical practices if the activities were within the four pillars and the practitioner could demonstrate training and competency. (CSP 2008 pg7).

Here for me was the paradox; if physiotherapy practice is continually evolving by taking on new roles “what is physiotherapy?” In her essay, Parry (1995 p310) described physiotherapists as “doers who function in the here and now to solve problems with an imperfect understanding of how they reached their current position and no coherent view of their knowledge base.” Understanding the experiences of physiotherapists extending the role could confirm such a view or uncover a different perspective. Secondly, Oreg et al (2011), in reviewing the literature

on organisational change, identified that the way recipients respond to change is central to whether it succeeds. If change is perceived as an opportunity, or alternative that can be embraced, then the outcome can be positive and rewarding. However, the converse can be uncertainty, frustration and anxiety and that this, together with threat of job loss, changes in responsibilities and transfer of authority, can lead to increased stress. The impact of change on ESPs has not been explored. With a desire to understand why and how these roles are created and the experiences of those involved in changing physiotherapy practice I began the research journey.

Chapter Two: Background and Historical Perspective

2.1 Introduction

This chapter provides the context and background for the study introducing three key sections. The first considers national policy changes from 2000-2012 and the response from the healthcare professions particularly physiotherapy. These changes provide the backdrop to the participants' workplace environment. The second section briefly examines the notion of extended clinical practice. This is not a new development within physiotherapy with the first article appearing in 1989 (Byles and Ling 1989), nor is it unique to physiotherapy. Referring to other healthcare professions this section identifies the ambiguity and confusion about the nature of such roles within a profession. The final section begins with the concept of a profession drawing on the sociology of professions before considering professions as institutions. In doing so the concepts of institutional entrepreneurs and institutional work are introduced and how these can be applied to the changes taking place with ESPs. This provides the background for the literature review which focuses firstly on the experiences of being an ESP and secondly how the concept of institutional work has been applied to the work of individuals engaged in institutional changes. So, to set the context the changes occurring in the NHS at the time are now considered.

2.2 National Policy Changes

Currie et al (2009) argue that the NHS modernisation agenda is often justified as making the service fit for the demographics, social, economic and cultural demands of the 21st century. The NHS plan (DH 2000) devoted a chapter to staff working differently, emphasising the need for more flexibility and changes in responsibilities, role and existing care processes. The document "*A Health Service of all the talent: Developing the NHS workforce*" (DH 2000 p9) strongly suggested that the NHS workforce should be looked at "as teams of people rather than different professional tribes." It argued that traditional professional boundaries have held

services back and that the provisions of health service should depend on the skills of the staff and not job titles.

McDonald et al 2015 contend that one of the greatest catalyst for workforce change in the NHS was the introduction of the “European Working Time Directive” (Directive 2003/88/EC). This reduced junior doctors working hours and enshrined the rest period they were entitled to following night shifts. In effect, it reduced the number of medical staff available to meet the current demand but maintained the same cost within the NHS. The solution was to encourage other healthcare staff to fill the void by performing tasks and practices previously the domain of medicine.

The Allied Health Professions (Occupational Therapists, Dieticians, Audiologists, Radiographers and Physiotherapists) responded through documents such as: “Meeting the Challenge for Allied Health Professionals” (DH 2004), “10 key roles for AHP's” (DH 2004), “The Musculoskeletal Framework” (DH 2006) and “Framing the Challenge of Allied Health Professionals (DH 2008). They argued for, and in many cases, gave examples of, AHPs developing competences and skills which overlapped with other professionals, particularly medicine. In other words, AHP practitioners could carry out tasks that would otherwise have been done by another (more expensive) clinician thus allowing the optimum use of existing resources and value for money. The CSP argued that ESPs were a cost effective and efficient way to meet clinical demand (CSP 2010).

The government, elected in the UK in May 2010, sought significant cuts to public sector spending and, as part of this, the NHS was required to deliver significant cost savings, undergo a major re-organisation and at the same time improve the quality of service provision (Tailby, 2012). To put this into perspective Sturgeon (2014), in his evaluation of the health care reforms, argues that the 2010 White Paper, *Equity and Excellence: Liberating the NHS* and the 2012 Health and Social Care Act unveiled a robust pro-market agenda for the NHS including plans to allow commissioners to purchase services from ‘any willing provider’ and to allow up to 49% of NHS trusts’ work to be in the private sector.

The controversy around the programme of reform was so great that the Bill was subjected to a three month 'halt' in the legislative process, to enable the government to 'pause, listen to and reflect' on opinions towards the planned legislation from additional medical stakeholders and the public (Hawkes, 2011).

The pause produced significant changes to two key areas, firstly, to the structure of the National Health Service (NHS), and secondly to the delivery of NHS care. The name "GP Commissioning Consortia" was amended to "Clinical Commissioning Groups" (CCGs), in a move to appease other professional bodies unhappy at the apparent GP dominance in the commissioning process (Powell, 2011). In terms of the second key area, care delivery, the Act moved to deregulate care provision through the introduction of mechanisms that enabled 'any qualified provider' (AQP) to tender for contracts from the CCGs. These providers could be private, public or voluntary sector organizations. The introduction of AQPs shifted NHS professionals into an explicit market context where they compete for contracts against any number of statutory and non-statutory providers as part of wider moves intended to instil market competition into public sector provision.

Davis (2013) argues that in simple terms, the main theme of the reforms was to make the NHS market more 'real'. Physiotherapy, particularly musculoskeletal outpatients, had been subject to tendering for contracts with the private sector and community health services since GP fundholding in the 1990s (Mallett et al 2014). The impact of these changes on hospitals was a greater emphasis on business models, increased focus on costs, an increased need to meet performance targets and holding services or individuals accountable through performance reporting (Killiher and Parry 2015). Although the NHS has been subject to on-going change throughout its history, Carlisle (2011) argues that the speed and depth of these changes represented a departure in magnitude from previous change initiatives, resulting in significant, new challenges. It is within this context of change that the study is set. The effects of this from an ESP perspective were unknown.

2.3 Extended Scope Practitioners

Within the CSP there are specialist clinical groups represented by professional networks. These are an important source for establishing current and credible custom and practice within comparable groups of the profession (CSP 2013). One such professional network is the Extended Scope Physiotherapy Practitioner Network (ESPPN) which describes extended scope of practice as “physiotherapists working at a high level of expertise who have extended their practice and skills in a specialised clinical area.” (ESPPN 2012 p1). The name relates to expert professionals undertaking skills previously outside the recognised scope of their profession. To complicate matters, the paper points out that ESPs do not necessarily use the word 'extended scope' in their job title and may be called Clinical Specialists, Advanced Practitioners, Orthopaedic Practitioner or Consultant Physiotherapists. The different job titles are determined locally and this ambiguity of title and role definition is not unique to physiotherapy.

From a UK nursing perspective, Jones (2005) points out a lack of definition in roles between clinical nurse specialists (CNSs), nurse practitioners (NPs), advanced nurse practitioners (ANPs) and consultant nurses which McDonald et al (2015) argue has led to confusion for the public and debate among health professionals about the scope and competence required by advanced practitioners. More recently Ryley and Middleton (2016) identified that advanced practice nursing is an umbrella term often used interchangeably to describe advanced practitioners (APs), nurse practitioners (NPs) and clinical nurse specialists (CNSs). More importantly they found a lack of clarity around the educational preparation required to work safely and effectively at a level above that of initial nurse registration. This is not unique to UK nurses and similar findings have been reported on role definitions and scope of practice in Canada (van Soeren et al. 2009) and Australia (Scanlon et al 2016).

In radiography Hardy and Snaith (2006) and Snaith (2016) contend that extended practice is task orientated and driven by the needs of the organisation to provide a coherent service. In

contrast, advanced practice is the successful synthesis of individual and professional qualities, based on the attainment of a higher level of professional knowledge and ability which are used to inspire and motivate improvements in the service. They argue that not all radiographers undertaking extended roles are advanced practitioners, which is where they believe the profession should be focused.

Returning to physiotherapy, Kerstein et al (2007) found that defining the term “extended scope of practice” was difficult due to the different nature of the roles and ambiguous definitions. However, they found some emerging agreement regarding tasks that were considered to be extended scope, such as ordering and interpreting plain film X-rays, limited prescribing rights, limited ordering of pathology tests, and specific injection tasks (Kerstein et al 2007; Stanhope et al 2012). The literature on ESPs focuses on reducing patient waiting times to medical specialist appointments (particularly orthopaedics) and comparing the clinical outcome of ESPs with that of their medical colleagues (Saxon, Grey and Oprescu 2014). Despite the growth of ESP roles robust evidence to support these service and professional developments is lacking (Kerstein et al 2007; Stanhope et al 2012). ESPs are recognised within physiotherapy (CSP, 2008,2016) yet understanding the development of these roles and the experiences of physiotherapists in these roles has not been explored leading to confusion to “who is doing what and why” (Kerstein et al 2007 p235). The first objective of this study will answer the what and why through the experiences of the ESPs.

Change in physiotherapy can be viewed within a sociological perspective of professions. Briefly, this section begins with a theoretical framework which describes the function of professions in society. It moves on to the concept of professional boundaries and the dynamic interplay between professions in maintaining their position within society. Finally, it argues that by viewing a profession as an institution the role of professions, and individuals within a profession involved in the process of change, can be considered using the concepts of institutional entrepreneurship and institutional work.

2.4 Professions, institutions and how individuals work to change them.

There are a variety of descriptive and theoretical perspectives on the development of professions and their position in society. Friedson (1970) described a profession as an occupation that has achieved autonomy because of society's acceptance of its claim both to exercise an important and esoteric knowledge-based skill and to be exceptionally trustworthy. Alternatively, Larson (1977 ch5) coined the phrase 'professional project' to describe the systematic attempt by an occupation to convert their knowledge and skills into social and economic rewards. The aim of the project was to gain social closure through the monopolizing of knowledge and services owned by the profession and control of the market. This notion of closure is linked to professional identity and a discrete and recognisable area of work (Currie et al 2009). Consensus can be traced around several core characteristics of a profession such as: an esoteric or discrete knowledge base, a formal training programme, self-regulation and a public-spirited ethos (Muzio et al 2013). The CSP defines physiotherapy as a profession that fulfils these criteria (CSP 2010) and if this is taken at face value it becomes pertinent in this study.

Firstly, ESPs performing new roles and tasks use the knowledge and skills of another profession (mainly medicine) so the degree of individual professional judgement and autonomy exercised by ESPs when practising is unknown. They may be closely supervised by medical staff, in which case, their autonomous practice may be less than a physiotherapist working in mainstream physiotherapy where they are clinically accountable for their own practice and accepted by patients as physiotherapists.

Secondly, the development of new roles represents a challenge to traditional roles and modes of service delivery and may be perceived as a threat. How other professions (and professionals) react raises the important question of how these boundaries are adapted or maintained during periods of change both from the challenger (the ESP) and the incumbent.

Abbot (1988) has a dynamic view of professions in which he describes an occupation as a service with a substantial control over the theoretical basis of its work. The success of a profession is based on the social tie of jurisdiction that binds profession and task together to provide a recognised right and a legitimate link between the two. Jurisdiction is an exclusive claim to an area of work which is established and maintained by a profession in relation to other professions in the same domain. Every move in the jurisdiction of one profession affects those of another. Abbott (1988) argues that these jurisdictional claims are made in three arenas. One is the legal system which can confirm formal control of work through legislation and law. The second is public opinion where professions build images that put pressure on the legal system and the government to substantiate the claim. The final one is in the workplace where official and public jurisdiction become blurred and distorted which leads to the professional problem of reconciling this public and workplace position.

Abbot (1988) contends that the competencies of individuals are visible and the pressure of getting work done means that professional boundaries cannot be strictly maintained. The inter-professional division of labour becomes an intra organisational one which is established through negotiation, custom and situation specific rules of professional jurisdiction. It is in the workplace that the complexity of professional life has its effect in a “fuzzy reality” (p66). At the centre of this idea is inter-professional conflict which may be resolved through negotiation (Nacarrow and Borthwick 2005) or covert competition (Sanders and Harrison 2008) or inter-professional equity and collaboration (Carmel 2008). Through these processes professional boundaries are defined or redefined over time and in response to external pressures. The experiences of ESP establishing these new professional boundaries with others is yet to be explored.

Adler and Kwon (2013) assert that the traditional autonomy of professions and the control over their work is being challenged by growing pressures of market competition and accountability outside of the professions. Muzio et al (2013 p707) suggest that in viewing professions as institutions they can be considered not “unique labour market shelters or conclaves of elite

social interest but rather as one of many forms of institutions struggling for jurisdiction and control over a social and economic sector.” Such a notion can be applied to the CSP, advocating and working with the Department of Health on advanced and innovative roles for physiotherapists (DH 2008) and encouraging members to move the profession forward by taking on medical tasks to meet health care demand (CSP 2010). To complicate matters these proposals must develop within the NHS, which as an institution has its own expectations, rules and structures. It has accepted ways in which professional groups interact to provide patient care (McCann et al 2013). It has a history and control over an area in society but more importantly it is experienced by individuals as an objective reality.

Institutional theory focuses on the way institutions constrain activity. The emphasis is on individuals or collectives being moulded by the institution (Battilla and D’Aunno 2010). Practices, norms and values became institutionalised (widely accepted, used and taken for granted). Institutional pressures, thus, have become identified as sources of stability and conformity among organizations (Suddaby and Vialle 2011). However, a core problem for institutional theory is to explain instances of change because organizational actors are embedded in institutionalized world views and taken-for-granted assumptions (Dacin et al 2002). The word actor refers to an entity engaged in change. This could be professional organisation, such as the UK College of Paramedics, trying to influence government policy (McCann et al 2013) or the state implementing new regulatory controls on executives’ pay (Adamson et al 2015). It could be a group of individuals such as interculturalists (i.e. trainers, coaches, consultants, advisors or educators in fields related to (cross-)cultural diversity) grouping together to lobby and advocate professional status (Szkudlarek and Romani 2016) or an individual, such as James Meredith and the integrationist movement at the University of Mississippi in the 1960s (Smothers et al 2014).

Actors are the entity but they achieve change or stability through their agency which Giddens (1979) describes as a reasoning actor's capacity to act or not to act. This concept of agency accounts for the fact that individual actors are not only constrained by the institution but

through action within an institution they can reshape the institution in certain circumstances (Battilana and D'Aunno 2010). Agency is associated with terms such as motivation, will, intentionality, interest, choice, autonomy, freedom and is linked to the actors' abilities to operate somewhat independently of the determining constraints of social structure (Mair and Mair 2010).

To complicate matters, agency does not occur in isolation, several groups may emerge and engage in parallel institutional activity. Actors may find they are competing against and impacted by, others with different agendas. Therefore, institutional change is likely to involve collaboration, co-creation and competitive convergence to ensure that the interests of various actors are embedded in the new institution (Zietsma and McKnight 2010). Effective institutional action recognises the interdependence of incumbents (those already in place) and challengers in which humanly devised rules are negotiated and agreed to make social life predictable and meaningful (Hargreaves and Van De Ven 2010).

Battilana and D'Aunno (2010) argue that actors are influenced by past actions and thoughts, present demands and ambiguities and the future by imagining how thoughts and actions could be adapted and negotiated to provide a desired outcome. In taking this view agency has a temporal quality, informed by the past, orientated to the future but based in the present. It also adds a further aspect to agency in that action may be influenced by a time dimension, based on previous experiences, current opportunities or future ambitions, aspects of which may be pertinent when considering the experiences of ESPs.

Institutional arrangements place constraints on actors and shape their practice by providing the standards and behaviours required for recognition and legitimacy within the environment. However, paradoxically actors can change institutional arrangements through negotiation, experimentation, competition and learning which over time becomes a shared understanding of problems and solutions (Zietsma and McKnight 2010). Institutional entrepreneurship focuses on the nature of these struggles and how actors attempt to influence existing and emerging institutional configurations. Battilana et al (2009) argue that institutional

entrepreneurs fundamentally pursue change to realize their own interests. This can be a struggle as those that hold power and control are motivated to maintain institutional arrangements to preserve their position of privilege. Several authors have identified how elite entrepreneurs use change projects to preserve their influential social positions rather than change arrangements that allow other actors to enter the field (Greenwood and Suddaby 2006, Currie et al 2012).

Suddaby and Lawrence (2006) introduced the concept of institutional work to describe how actors affect institutions. The concept was based on a growing awareness of institutions as products of human action and reaction motivated by personal interests and agendas for institutional change or perseverance (Lawrence et al 2010). They suggest that by careful analysis of the complex motivations, interests and efforts of actors the patterns of intent and capacity to create maintain or alter institutions can be explored and understood. Further they argued that individuals are a crucial component in understanding the nature of institutional work within an organisation (Suddaby et al 2013, Lawrence et al 2013 Brvort and Suddaby 2015). Institutions and actions exist in an inter-woven relationship in which institutions provide templates for actions, as well as a mechanism that enforces those actions and that actions by actors affect these templates and regulation mechanisms (Lawrence et al 2010). Actors are neither pawns trapped by institutional arrangements nor super human institutional entrepreneurs able to stimulate change through personality or force of will (Suddaby et al 2013).

The focus of institutional work is on the activities of creating, maintaining and disrupting institutions rather than a set of successes or outcomes. This allows exploration of the why, how, when and where actors work at creating institutions (Muzio et al 2013). The emphasis on process provides an insight into what the intended and unintended consequences might be through the experiences of those involved in change. Fredrickson et al (2013) point out that too often the intentions of actors are not accomplished or the activities cause unintended

consequences. Rarely are these identified or considered when the focus of research is on the outcome.

In considering institutional work as a framework to understand the creation and maintenance of new roles there appears the possibility that this could be applied to the activity of ESP involved in change within physiotherapy. Recent studies exploring professions through an institutional work perspective have provided insight into how professions maintain their professional status in an organisation in the face of competition (Currie et al 2012) or reconfigure the organisational field (Kippling and Kirkpatrick 2013).

However, empirical studies of institutional work are relatively scarce (Adamson et al 2015). To aid the reader further description and details on the characteristics of institutional work and the different types of work involved in creating, maintaining or disrupting institutions are included in Appendix 1. It draws on the original work of Suddaby and Lawrence (2006) with additional example from more recent literature. The following chapter considers the literature on the experiences of ESPs before reviewing the literature applying institutional work to the work of individuals engaged in professional change.

Chapter Three: Literature Review

3.1. Introduction

The following literature review represents the two components of the research question; `To understand the experiences of ESPs`. The first part focused on the experiences of physiotherapists working as ESPs. The second part searched the literature for a concept or theory that provided an understanding of those experiences. The literature reviews were separate, both in the chronological time they took place in the research and the approaches that were used.

The first review followed a systematic approach but was not a systematic review. The dearth of papers relating to the experiences of ESP necessitated a broader narrative review of published systematic reviews. These predominantly reviewed the efficiencies and effectiveness of the ESP role rather than the experiences of physiotherapists practising in those roles. The following section outlines the steps taken in reviewing the literature and highlights the lack of current insight into the experiences of physiotherapists in ESP roles.

3.2. Being an ESP

The start date for the review was 1989 based on the earliest reference to ESPs (Byles and Ling 1989). The final search was conducted in January 2017. MEDLINE, PEDRO, CINAHL, AMED and the University research search data base were used. This was later expanded to the CSP database and library maintained on the CSP website. The focus was on the experiences of ESPs

Following the guidance of Bettany-Saltikov (2010) the search was structured around the **P** (Participants), **E** (Exposure) and **O** (Outcome) method and included the inclusion and exclusion criteria which are outlined in the table below. The P related to physiotherapists, the E to working as ESPs and the O was the experiences of working as that ESP.

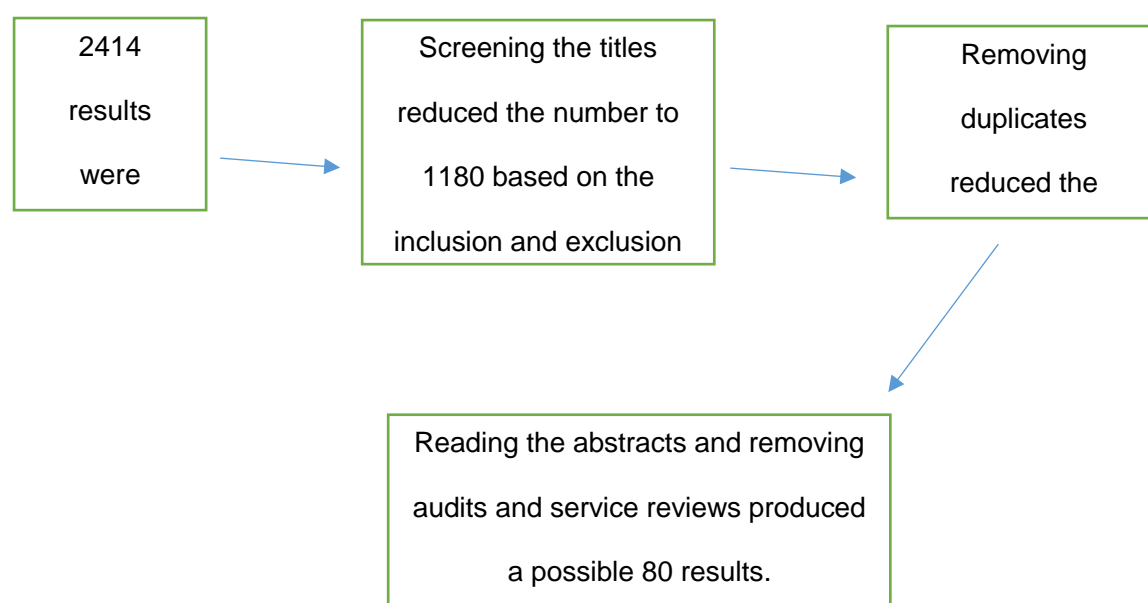
Inclusion and Exclusion Criteria for the Literature Search on the Experiences of ESPs

Criteria	Inclusion	Exclusion
(P) Participants	Physiotherapists	Other Professions
(E) ESPs	Extended Role Physiotherapists Advanced Practice Physiotherapists Hospital Setting	Physiotherapists Other Professions Community/GP Surgeries
(O) Outcome	Experiences	Audit Experience of others Others eg other staff or patients` perceptions of the role
Other	Qualitative or Quantitative Papers	
	Full text in English	
	Any country	

The three key search terms were physiotherapy, or physical therapist (the American derivative of physiotherapy), advanced practice and experiences.

Search Term	Search Term	Search Term
Physiotherapy Physiotherapist Physical Therapy Physical Therapist	Advance* practice* Enhans* scope Enhans* practice Expan* scope Expan^ practice Role expan* Role exten* Scope of practice Advanc* physio* practitioner	Experience of

From the initial searches



These papers were read and interpreted based on describing the experiences of ESPs.

Most of the literature highlighted the effectiveness and cost efficiencies of ESP roles when compared with medical staff (Sephton et al 2010; Hourigan, Challinor and Clarke 2015; O`Mir at al 2016). Several studies describe tasks undertaken by ESPs, including: triaging, referral to other services (including medical specialists), requesting investigations (radiology, pathology), diagnostic ultrasounds, medication (limited prescription, monitoring, dosage changes), joint injections (recommend or perform), removing K-wires, simple suturing, and prescribing conservative management or treatment (Holdsworth, Webster, McFadyen 2008; Kersten et al 2007; Lineker 2012; Stanhope et al 2012).

Each paper was assessed using a hierarchy of evidence based on the guidance suggested by Aveyard (2010). The following outlines the process with examples.

3.2.1. Hierarchy of Evidence

- 1) **Systematic review of qualitative studies of ESP experiences**
- 2) **Qualitative or quantitative studies of ESP experiences**
- 3) **Expert opinion**
- 4) **Anecdotal opinion**

Author/Country	Methodology	Experiences of ESPs	Role of ESPs	Relevance
Atkins (2003) UK	Descriptive phenomenology but not explicit. Convenience sample. Participants from several clinical areas (private practice, occupational health)	Yes, but sample focused on ESP experience of introducing injection therapy into clinical practice.	1)Autonomy 2)Relationship with consultants 3)Lack of education and training.	Aim of the study was to development a theoretical framework to underpin the training of physiotherapists and to facilitate the implementation of injection therapy into professional practice. Code 2 with limitations
Dawson and Gharzi (2004) UK Snowball sample of 4 ESPs	A qualitative approach looking at "meanings, trying to understand phenomenon and develop theory" (p211)	Experiences of; 1)Becoming part of the team 2) Establishing support networks. 3)Meeting training needs. 4) Emotional	Ad hoc training, role developed in conjunction with named consultant.	Limited time frame within which the study was to be conducted. Focused on training, responsibility, support,

	Thematic analysis following the first five of Colaizzi's procedural steps. Themes reviewed by independent researcher.	response to new role 5)Professional development;		satisfaction and recommendations. Code 2
O`Mir et al (2016) Eire	3-year audit of 2650 patients. No independent scrutiny	Nothing on the experience	Successful management of extended clinical case load	Code 3
Kerstein et al 2007 UK	Explored the range, drivers and perspectives of ESP roles. Systematic review of 19 databases. 152 resources but no meta- analysis due to no RCTs	Nothing on experiences. Ref to Dawson and Gharzi (2004) and Aitkins (2003)	Studies all supported the role. All of them were descriptive and were criticised for lack of robustness.	Systematic review of the roles and nature of ESPs. Code 1 However, nothing on experiences. Last papers reviewed 2005
Gardener and Wagstaff (2001) UK	Commentary piece on the debate between physiotherapists in Stepping Hill hospital on the role of ESPs	ESP wanting to be different, not wear a uniform and have a distinctive title.		Opinion code 4
Morris et al (2015) Australia	Focus on ESPs in emergency departments. Although described as an observational study it appears more like an audit against certain benchmarks. For example, waiting times, outcomes etc. Includes patient satisfaction but only includes 11 patients over 53 weeks. (10 satisfied)		Concludes that ESP can successfully manage cat 4 and 5 patients (minor injuries)	Audit code 3
Saxon et al (2014)	Systematic review search strategy mirrored Kerstein et al to include articles from 2005-2013.		Despite the earlier review calling for more robust evaluations regarding the impact on	Review also included OT and dieticians and found similar weaknesses. Nothing reported

	A total of 1,000 articles were identified by the search strategy; 254 articles were screened for relevance and 21 progressed to data extraction for inclusion in the systematic review.		patient outcomes, cost effectiveness, training requirements, niche identification, or sustainability, there appears to be limited research reported on the topic in the last 7 years.	on the experiences of these ESP roles. Code 2
Thompson et al (2016)	Systematic review of orthopaedics/MSK and ESPs identified 426 articles reduced to 25 (22 quantitative and 3 qualitative) from 2004-2013		Draws on descriptive and outcome audits. The 3 qualitative papers identifies that there is poor understanding of the role from GPs and Patients.	Code 2
ESPPN (2012)	Special interest group reviewing nature of ESP roles. Collecting evidence of change in practice and innovation.		Types of role and “showcasing” new developments. Advocating the role.	Peer support/Expert opinion. Code 3

Only two papers specifically investigated the experiences of physiotherapists taking on new extended roles. The first was a small qualitative study of physiotherapists working in ESP roles in Scotland (Dawson and Gharzi 2004). The second investigated the experiences of physiotherapists implementing a new treatment technique (the use of steroid injection in the management of musculoskeletal injuries) into clinical practice (Aitkins 2003).

3.2.2. The Experience of Being an ESP

Dawson and Gharzi (2004), used a snowball sampling technique and interviewed four physiotherapists working within orthopaedic clinics. The semi-structured interviews focused on training, responsibility, support, and satisfaction with the role. The questions were asked in the same sequence in each interview and were completed over a four-week period. The paper outlined specific questions and the areas of questioning the study would concentrate on. It could be argued that the interview was more structured than intended because of a specific purpose. Dawson and Gharzi (2004 p211) initially contend that the study was aimed at investigating “the feelings and perceptions of physiotherapists in post....trying to understand the phenomenon and develop theory.” However, they conceded that the topics for discussion were predetermined based the authors experiences and the purpose of the research was to produce guidelines. The researchers had pre-set questions in a sequential order on topics they had already decided were relevant. In the paper, there is no link to understanding or theory and there was the possibility of researcher perceptions influencing the interpretation.

Secondly, the interview transcripts were not returned to the participants for checking and the study deliberately used only four participants. The reason given for this was “the time frame within which the study was conducted” (Dawson and Gharzi 2004 p211). The phenomenological methodology requires time to become immersed in the data (Smith et al 2009) and time for writing and rewriting to grasp the essence of the experiences (van Manen 1992). It also requires a sense of discovery in analysing the data (Langdridge 2007) rather than a pre-conceived or expected outcome. The timeframe of this study, and the accepted pre-conceived ideas and structured interviews conducted by the authors, challenged whether the experiences were discovered or simply manufactured by the framework of the questioning and expectations of the authors.

Being aware of the above caveats, Dawson and Gharzi (2004) identified the importance of the relationship with the consultant. All four participants described how the consultant provided the education and training for the role. There were no other means to gain this experience and they relied on the consultant to provide the training and sanction them as competent. They described “learning to think like their consultant” (Dawson and Gharzi 2004 p213). This created a dependence on the consultant and the participants described working very hard to be part of the team.

The success of the ESP posts, and the feelings of the practitioners, were related to the personal and professional relationship they had with the consultant. Gaining acceptance was an important aspect of role development and career satisfaction. One participant described

difficulties establishing her role due to resistance from medical colleagues to the ESP concept. She believed that they would have preferred another doctor in post and described feeling a lack of support from the consultant. This impacted on her job satisfaction so much that she was considering resigning. Dawson and Gharzi (2004) concluded that ESP roles are moulded by the consultant in response to local needs. They suggest that further developments of these roles would require training before starting the roles, establishing a professional network with other ESPs to provide support and clear definitions and expectations of the role.

Dawson and Gharzi (2004 p214) recommended that post should only be “set up at the request of, or with the full backing of the orthopaedic team and that expectations and responsibilities should be defined at the onset.” This seemed at odds with the dynamic physiotherapists described in evidence to the Department of Health (DH 2008) as problem solvers meeting health care demands. The participants in Dawson and Gharzi (2004) study seemed passive and reliant on the consultant for direction and permission to practise. There appeared a dichotomy between these participants and the expected ESPs in the CSP strategy document (CSP 2010).

In the other study, Aitkins (2003) interviewed 11 participants from primary care, private practice, hospital settings and one from a non-NHS occupational health department who had attended the same injection course. Using a phenomenological approach and semi-structured interviews similar themes were identified. The participants identified the need to be attuned to the consultant's opinion and their ways of working. Although not explicitly stated, it is inferred, that this was needed to gain the support of the consultant and so smooth the transition into practice. They were reliant on the consultant for training and the ESPs assimilated into their roles by attempting to mirror the behaviours of their consultant colleagues.

Training was an ad hoc arrangement with the ESPs, attending training with medical registrars and junior doctors or, shadowing alongside the consultant. Problem solving and clinical situations were used as learning opportunities to discuss and reflect with the consultant at the end of clinics although no formal reflective logs or learning journals were used. These findings were supportive of the views of Dawson and Gharzi (2004) that practice developed in one hospital may be accepted as normal while at a nearby hospital such practice would be taboo. It also means that the ESPs could only practice in the environment controlled by the consultant and that their clinical skills were not transferable to another hospital. Further, Aitkin (2003) confirms, yet again, a picture of ESPs as passive hand-maidens to the consultant. There is no insight into how the roles developed nor the relationship with other clinical groups.

Dawson and Gharzi (2004) made a point, but do not elaborate, on the relationship between physiotherapists and ESPs. They inferred that the ESPs saw themselves as different to their

physiotherapy colleagues but that physiotherapy colleagues did not afford them any greater status or respect. There is only one other reference to support a potential differing of opinion between physiotherapists. In a short essay, Gardiner and Wagstaff (2001) describe ESPs at their hospitals wanting to be different, arguing for a non-uniform policy and a new title. The literature review revealed a significant gap in understanding the experiences of individuals performing ESP roles.

To gain more clarity evidence from the systematic reviews identified were investigated to establish whether they could provide any further insight into the experiences of ESPs. The following umbrella review of these is discussed below.

3.2.3. Narrative Review of the Systematic Reviews of ESPs

During the literature searches several systematic reviews of ESPs roles were discovered (Kerstein et al 2007; Stanhope et al 2012; Desmeules et al 2012; Saxon, Gray and Oprescu 2014; Oakley and Shacklady 2015; Thompson et al 2016). All were critical of the quality of research on ESPs and their roles and found difficulty drawing conclusions.

Kerstein et al (2007) concluded that the reason physiotherapists extended their roles was to increase their professional autonomy and clinical skills. They argued that the pace of these developments was driven by policy initiatives and the enthusiasm of the staff. They arrived at this conclusion based on the lack of quality research and the propensity of ESPs to publish the results of audits which all supported the development of the role and highlighted its value to healthcare. They went further and argued that ESP roles were justified and supported on “poorly conducted audit and research of limited value which were then widely cited by individuals and organizations as evidence.”

Two further reviews arrived at the same conclusion but also raised concerns that the focus of ESP development was only related to orthopedics (Stanhope et al 2012; Desmeules et al 2012). Both reviews identified that many of these practices were protocol driven and based on a model of examination and management devised by the orthopedic surgeons. The role of the ESP in shaping these protocols could not be identified. It raised the possibility that the increased professional autonomy identified by Kerstein et al (2007) as a driving force for ESPs was an illusion. It may be that they had less autonomy than their other physiotherapy colleague in that they were performing a prescribed course of action outlined and directed by a consultant.

There was a wide variation in training between practitioners and it was unclear whether the training reported in the studies was required before taking the role or simply a description of the physiotherapist's role in the area (Kerstein et al 2007; Stanhope et al 2012). The only two studies on the experiences of ESPs identified that training was ad hoc and delivered in house by consultants as the role developed (Aitkin 2003; Dawson and Gharzi 2004). There was no training course that produced an ESP with competencies before they started the role. There was also scant knowledge about the experiences of physiotherapists stepping into these roles.

Concerns were also raised that in all the published audits of ESP roles the efficiencies and effectiveness of the roles; patients' satisfaction with the service received and that the roles were a means to meet health care demand are all identified. They all emphasized the positive impact of such roles and the recommendation of further development (Oakley and Shacklady 2015). There has been a lack of critical analysis of such roles and no downsides or failures of the role recorded (Saxon, Gray and Oprescu 2014). This would appear unlikely but highlights the lack of knowledge and understanding of the development of such roles and the experiences of those physiotherapists who take on such tasks.

Morris, Vine and Grimmer (2015), in considering ESP roles in Australia, looked to the UK for evidence. They concluded that the key reasons for introducing these new roles was to meet demand and address newly introduced service access targets. Most of the research into the impact of ESPs report on outcome measures, cost and access. However, because of local service demands, the new physiotherapy roles were introduced without nationally-planned training or credentialing.

It therefore appeared that physiotherapists were trained and credentialed in-house in reading imaging, prescribing and using medicines (including injecting). While this met local and national access requirements, in-house ESP training means that few ESPs could work in this same role across hospitals as their skills were not recognized. The literature review revealed a gap in knowledge about the experiences of physiotherapists in ESP roles and the way these roles were integrated into clinical practice. There was no knowledge or understanding of the successes or failures in changing practice or insight into the relationships that develop between different clinical professions and the impact all of this has on the individuals concerned. It appeared that research into the experiences of ESPs was a new and original area to investigate that would provide useful information for physiotherapists.

The second part of the research question was to provide a framework or concept that could be used to understand the experiences of ESPs. The following section outlines the nature of the search for this framework and the evidence which suggests it provided a means of understanding the experiences of the ESPs.

3.3 Understanding the Experiences of Being an ESP

3.3.1. Introduction

This literature review began after data analysis revealed the experiences of being an ESP. The aim of this review was to find a concept or theory which provided an understanding of these experiences. Finfgeld-Connett et al 2013 (p199) argue that this process cannot be definitively mapped from the outset, nor is it easily reconstructed at the conclusion. “The route involves many twists and turns and to-and-fro movements that defy simple cartography. By the time the researcher has come to the end of the search, it may be difficult to remember exactly how the journey started or what route was taken.” However, even though there were no preconceived ideas about the route the study would take there was still a need to provide a systematic structure to the literature review (Aveyard 2010). This process is captured in the reflective diary and the pivotal moment when the review achieved focus is attached in appendix 8.

The review began using the term “sociology of professions.” This provided a background and definitions of professions. Given, the emergent nature of attempting to find an explanation to understand the ESPs` experiences, the search was time consuming and messy. The moment of insight, recorded in the reflective log (appendix 9), was the link between the sociology of the professions and institutional work in “*Professions and Institutional Change: Towards an Institutional Sociology of the Professions*” (Muzio, Brock and Suddaby 2013). The authors began with the premise that professions are institutions subject to change from those individuals working within them. By applying an institutional approach to the study of professions an alternative to functionalist and conflict based traditions could be considered.

To be explicit, as outlined in page 22, much of the work on professions either defined the concept, attributes and their place in society (Friedson 1970; Larson 1977; Currie et al 2012). Or described how professions developed and maintained their position in society through jurisdiction over an area of work and then maintained a boundary to keep out other professions from making a claim on this knowledge or skill (Abbot 1988). In contrast, Muzio et al (2013) introduced the concept of institutional work to account for the individual pursuing change within a profession and the relationships between professions because of that change. The concept of institutional work provided an explanation of how individuals, or groups of individuals, through their endeavors in the workplace could bring about change within a profession.

The next section provides detail on the concept of institutional work drawing on the original work of Lawrence and Suddaby (2006) before arguing that the concept can be applied to the individual engaged in changing professional practice.

3.3.2 Institutional Work

3.3.2.1 Introduction

Lawrence and Suddaby (2006; 248) argued that it was possible to take a broad view of institutions as existing across levels “from micro institutions in groups and organisations that regulate forms of interaction amongst members, to field level institutions such as those associated with professions and industry to societal institutions such as the family, gender, religion etc.” Institutional work explored the ways in which reflexive actors negotiated their institutional environment through “intelligent situated action” (Lawrence and Suddaby 2006 p219). The premise was that institutions and actions exist in an inter-woven relationship in which institutions provided the templates for actions, as well as a mechanism that enforced those actions and that actions by actors affected these templates and regulation mechanisms. It acknowledged the crucial effects of institutions on action which are important in understanding institutional work but it provided a focus on how action and actors effect institutions (Lawrence et al 2010).

In taking this view Lawrence and Suddaby (2006 p219) argued that institutional work is orientated around three key elements. The first highlights the “skills and reflexivity of individual and collective actors”. The second provided an “understanding of institutions as constituted in the more or less conscious actions by individuals” and a third captured an approach to action which accepted that “even action which is aimed at changing institutional order of an organisational field occurs within a set of institutionalised rules”. Lawrence et al (2013) argued that little is known of these experiences as much of it is nearly invisible and embedded in micro level mundane day to day practices. This has a resonance with the research question of trying to understand the experiences of the ESPs.

The study of institutional work placed an emphasis on the activity of creating, maintaining and disrupting institutions rather than a set of successes or outcomes. Institutional work focused on exploring the why, how, when and where actors work at creating institutions and the supporting or non-supporting factors which encourages some actors to engage and others to decline. Secondly, because of its emphasis on process rather than outcome an insight into the intended and unintended consequences can be identified through the experiences of those

involved in change. Fredrickson et al (2013) point out that too often the intentions of actors are not accomplished or the activities cause unintended consequences. Rarely are these identified or considered when the focus of research is on the outcome.

In considering institutional work as a framework to understand the creation and maintenance of new roles there appears, at face value, the possibility that this could be applied to the activity of ESP involved in change within physiotherapy and clinical practice. Recent studies exploring professions through an institutional work perspective have provided insight into how professions maintain their professional status in an organisation in the face of competition (Currie et al 2012) or reconfigure the organisational field (Kippling and Kirkpatrick 2013). However, empirical studies of institutional work are relatively scarce (Adamson et al 2015).

This section summarises the characteristics of institutional work and the various aspects of work involved in creating, maintaining or disrupting institutions drawing on the original work of Suddaby and Lawrence (2006). It provides additional example from more recent literature to provide an understanding of the concept and its application.

3.3.2.2 Creating Institutions

Lawrence and Suddaby (2006) argue that institutions do not arise by coincidence but are the result of actors with certain interests and abilities establishing rules, norms and beliefs.

They identify nine forms of work involved in creating institutions which are outlined in the table below.

Forms of Institutional work	Description
Advocacy	Gaining political or regulatory support through persuasion for change.
Defining	Boundaries and rules are constructed that focus on establishing the parameters of future institutional structures and practise.
Vesting	Establishing new rules that confer rights on the new institution through an implicit contract which holds the change agent responsible to an authority (be that the state, professional body etc). In doing so a framework is constructed.
Constructing Identities	Primarily associated with the development of new professions or the transformation of existing ones. It describes the relationship between the actor and the field in which they practised.
Changing Normative Associations	Often leads to new institutions that run parallel or complimentary to existing one. While not directly challenging the existing institution, the actors stimulating this change and begin to take on some of the roles of another profession sometimes using the arguments of efficiency and effectiveness.
Constructing normative networks	Describes work within an organisation through which new practises are monitored, evaluated and ultimately accepted as a new institution working alongside existing activities and structures.
Mimicry	Creating active links with existing sets of practice so as to make the new institution understandable to an outside audience.
Theorizing	Naming the new concept or practise and constructing chains of cause and effect.
Educating	Preparing the actors in the skills and knowledge necessary to support the new institution

The first three form a mutually reinforcing cycle in which support for change is first gained which enabled new rules (or legislation) to be established and therefore additional rights are conferred on the actors. "Advocacy" could include: lobbying, proposing new legislation or using advertising to influence how an institution was perceived by others. It might be argued that lobbying by professions such as nursing, physiotherapy and podiatry for independent prescribing rights might fall into this category.

"Defining" creates the boundaries and rules that focus on establishing the parameters of future institutional structures and practice before the final stage of "vesting" in which these new rules confer rights on the new institution. These rights become an implicit contract which holds, for example a profession, responsible to an authority (be that the state, professional body etc.) and in doing so a framework is constructed.

The next three types of work focus on effecting norms and beliefs which underpin the role, values and framework of the institution. This is an internal process which may initially cause disagreement but ultimately relies on co-operation and agreement within the institution. "Constructing an identity" describes the relationship between the actor and the field in which they practised. The shared experiences of extended training give professionals a powerful sense of identity and a common language (Adler and Kwon 2013). With this shared experience, there is a sense of belonging which continues as they continue their post-graduate careers (Sparkes 2002). However, institutions do not exist in isolation. There are relationships with other professions (Zietsma and McKnight 2010) and within an organisation, professions establish remits and boundaries of practice (McCann et al 2013, Kipping and Kirkpatrick 2013). Both these internal and external processes combine to shape the profession by giving a collective sense of identity and an external perception by others.

"Changing Normative Association" often leads to new institutions that run parallel or complimentary to existing one. Andrews and Waernes (2011) in a study of Public Health Nurses (PHN) in Norway showed how over a period of 20 years their role diminished firstly by a change in the Municipal Health Service Act of 1997 which allowed midwives to take leader responsibility in Parent and Child Health Care Services on par with the PHN. This sharing of duties with another occupational group allowed midwives slowly to take on the previous profession's role by arguing that it was a natural extension of their role and they were qualified to do it. In doing so the practises became connected to the role of the midwife and part of their professional identity. Equally in the UK it has been argued that some of the roles traditionally undertaken by the family doctor or the physicians in A&E have gradually been accepted as nursing practice (Heale and Buckley 2015; Ryley and Middleton 2016)

“Constructing normative networks” describes work within a new institution which ensures new practise become compliant with existing standards. These are monitored, evaluated and ultimately accepted as part of a new institution working alongside existing activities and structures. This type of work aims to promote standards and practice that can be understood by others and gives confidence as to the quality of service or product on offer.

The final three types of work described additional methods of creating an institution. Mimicry describes the creation of active links with existing sets of practice. In doing so the new institution looks like or performs like an existing institution which makes it understandable to a target audience. At the same time, this new institution, begins to subtly points out the shortcomings of the existing institution in terms of its structure, practise or output while highlighting the its own benefits. This type of work provides an entry into a field because the new institution looks familiar to what already exists. It then slowly creates a distance between itself and the existing institutions.

Theorising begins with naming the new concept or practice so that it might become part of the cognitive map of the field (Lawrence and Suddaby 2006 p219). Naming is a crucial first step which allows further development but it also allows communication of the concept and further elaboration through theorising. Relevant to this study could be the naming of physiotherapists as ESPs which links them to new practises and new roles. “Education” prepares the actors in the skills and knowledge necessary to support the new institution. It involves creating templates for learning so that others can successfully follow which is recognised and credible. It forms a crucial part of the process in that the acquisition and recognition of these skills depends on the quality and outcome of the education.

Lawrence and Suddaby (2006; 222) concede that their concept of creating institutions is a “sketch of the terrain” rather than a list of what has to happen but it does highlight the efforts needed by actors. They suggest that institutional work with a focus on rule changes (vesting, advocacy and defining) are more likely to be associated with wholesale construction of new institutions which could be established relatively quickly through the influence of the state and legislative bodies. Adamson et al (2015) in their study of Executive Remuneration Consultants (ERCs) showed how the UK government created these roles, defined their remit and vested powers in them through legislation following concerns about directors` pay awards and the weak link to company performance. Using company law ERC were created to independently advice, and be held accountable for that advice, remuneration committees on executive pay based on market data and research and the performance of the company.

In contrast, changing norms and beliefs is more associated with creating institutional rules and practices that run parallel or complement existing institutions. Consequently, this depends on

the co-operation of other actors within the field to support or not hinder change. Zietsma and McKnight (2010) identified that while these categories of institutional work are theoretically distinct they occur throughout the whole process of institutional change sometimes simultaneously. In their study, they found that change involves trade-offs usually through the adaption of the new institution to include something that will privilege or protect the interest of supporters. Institutional creation is unlikely to be “winner take all” and the mechanism of collaboration, co-creation and competitive convergence ensures that the interest of various actors are embedded in the new institution to the extent that those actors can command support and resources. Organisational stability depends on stable interpersonal relationships which can support change.

3.3.2.3 Maintaining Institutions

The second type of work within the concept is maintaining an institution once it is created or maintaining an institution in the face of challenge. The six types of work are described in the following table.

Forms of Institutional work	Description
Enabling	Structural arrangements through negotiation, both at the macro level and micro level, so as to avoid intra-institutional conflicts through agreeing working models and boundaries which are then maintained
Policing	Ensures compliance through enforcement, auditing and monitoring.
Deterring	A threat to ensure the compliance of the institutional actors. At its extreme, this could be expulsion from the institution for an actor.
Valourizing and Demonizing	To create through reinforcing the positive aspects and benefits of the institution, which could include how safe it is, how effective it is, what it has contributed to the health of the nation etc. In contrast demonizing focuses negative attention on other parties who threaten or challenge the institution. The use of this is to provoke uncertainty and concern in an alternative institution while emphasising all the positive qualities in the current arrangements.
Mythologizing	Establishing a past and reputation which can sustain the present and maybe the future.
Embedding and Routinizing	Making all practice routine and part of organisation. Practices become repetitive and accepted as day to day activity. Stability is added to the institution as such practise becomes the accepted norm.

In summary, the first three, “enabling” “policing” and “detering” ensure an ongoing adherence to the rule system. The other three “valorising and demonizing”, “embedding routine” and “mythologizing”, focus on reproducing existing norms and belief systems.

“Enabling” work introduces structural arrangements through negotiation, both at the macro level and micro level, to avoid intra-institutional conflicts through agreeing working models and boundaries which are then maintained (Greenwood et al 2002). In contrast “policing” ensures compliance within the institution through enforcement, auditing and monitoring and can include both penalties and inducements. In both types of work practice and boundaries are monitored and controlled. These are then reinforced by the work of “detering” which has within it a threat to ensure the compliance of the institutional actors. At its extreme, this could be expulsion from the institution for an actor. These three types of work are usually visible and actors are aware of the function in maintaining and preserving the institution. These three types of work, enabling, policing and deterrence act together to provide to make real the coercive foundations for an institution (Lawrence and Suddaby 2006).

The next three types of work are more long-term activities. In “valorising and demonising” there is a twin pronged attack if needed. In valorising an institution works to portray a public face which is recognisable and carries status. This is maintained through reinforcing the positive aspects and benefits of the institution, which could include how safe it is, how effective it is, what it has contributed to the health of the nation etc. It may draw on its history which is then projected into the present to explain its values and achievements. All of which reinforce a positive impression. In contrast demonizing focuses negative attention on other parties who threaten or challenge the institution. A recent example would be plastic surgeon’s public criticisms of the “beauty industry” and other surgeons, not on the plastic surgeons’ register, undertaking cosmetic procedures. In doing so the plastic surgeons argue that these practitioners were unsafe, caused harm and were unregulated in contrast to their own extensive training and regulation (Gimlin 2014). The use of this concept of demonising provokes uncertainty and concern in an alternative institution while emphasising all the positive qualities in the current arrangements.

“Embedding” works to make all practice routine and part of the institution. Practices become repetitive and accepted as day to day activity. Stability is added to the institution as such practice becomes the accepted norm. The final factor in maintaining institutions is more nebulous and links the past to the present by creating a myth or reputation. Great store is place in the history of an institution particularly when place in a positive light. Hughes and Vincent (2008 p400) argue that people believe in the NHS with something “bordering on religious conviction, seeing it as the embodiment of British values of fairness and social

solidarity". With such a strong tradition, the NHS is still maintained and in existence despite significant pressures and competition. "Mythologizing" establishes a past and reputation which can sustain the present and maybe the future.

Maintaining an institution is not simply a matter of standing still but is better viewed as a process of adapting and realigning to change. Jarzabkowski et al (2010) in their study of a utility company coping with other companies entering the market found that maintenance occurred as a pattern of move and counter-move in response to others and that this was not an occasional activity but an ongoing process which occurred in phases. Hargreaves and Van De Van (2010) identified that actors act to realign arrangements and relationships which promotes stability and a degree of certainty and is sensitive to the environment in which it is situated.

Maintaining work emphasizes how rules, norm, ideas and practices are formed and transformed. The coercive dimension promotes compliance with existing rules through and the normative dimension promotes the institutional norms and belief systems. It builds on extensive interaction and communication which enables behaviours to become legitimate and distributed commonly described as institutionalised (Friedrickson 2013).

3.3.2.4 Disrupting Institutions

These three types of institutional work focus on disrupting controls which underpin an institution and so force change. They are summarised in the following table.

Forms of Institutional work	Description
Disconnecting Sanctions	Focuses on the state changing regulations with the result in large scale change aimed at stimulating a solution to solve a significant problem.
Disassociating moral Foundations	Undermining indirectly through changes in practise that challenge an established institution and its reason for being in place.
Undermining assumptions and Beliefs	This type of work can be achieved through the success of contrary practices.

These types of institutional work focus on disrupting controls which underpin an institution and forces change. This can be achieved through, "disconnecting the rewards system or sanctions", "disassociating the moral foundations" of the institution or "undermining core assumptions or beliefs" which give structure to the institution. The emphasis is on undermining

the mechanisms that lead members to comply with the institution. Lawrence and Suddaby (2006) argue that in some of their case studies the creation of new institutions in the same domain can have a disruptive impact on other institutions. They found from their limited studies that such effects are gradual over a prolonged period and were instigated by significant change at the level of the state.

The examples of disconnecting sanction/rewards focus on the state changing regulations with the result in large scale change. The examples given are on a macro level and include the American radio industry after the world war two and fish quotas for Norwegian fishermen in the 1990s. Both appear to be centrally driven, in times of crisis such as war or financial crisis, and both aimed at stimulating change to solve a significant problem. The changes in regulation opened markets and allowed new entrants to succeed at the expense of established institutions. In “dissociating moral foundations” the change is at a societal level where controls are lowered allowing change occurs. Being different and doing things differently impacted on the established institutions which are seen in a less positive light. This can be stimulated by introducing new technologies or practice which are seen by the public as positive compared to the current arrangements. Incrementally the process of change creates a new institution or adapts an existing one. In doing so it challenges the established institutions to react to the competition.

The final category of disrupting institutional work involves undermining core assumptions and beliefs. This might occur through successful innovation and success. The success of the innovation forces other actors to reconsider their assumption and beliefs and allows for change. These changes Lawrence and Suddaby (2006) argue are likely to occur at boundaries be they social, professional, cultural or moral and the actors involved less effected by the governance mechanisms of their institutional environment. Marti and Mair (2010) in their study of food agencies in the developing world found that this type of work can be achieved through the success of contrary practices. They observed actors disrupting established institutions and practise by adopting change that was experimental, incremental, careful and sensitive to the wider domain. By taking this approach, the new agency challenged the assumptions and beliefs of the established institutions and brought about change and recognition.

Lawrence and Suddaby (2006) concede that they do not know much about the work done by actors to disrupt institutions and this was an area needing further investigation. More recent studies have provided more examples. Gilmore and Sillince (2013) describe in detail how a well-established and reputable Sports Science and Medical department in a football Premier League club was disrupted and dramatically changed by the appointment of a new manager. Within weeks he had challenged their reason for being there, canvassed support from a

powerful Board of Directors and introduced an alternative model. In doing so he had disassociated the moral foundations of the institution and undermined core assumptions or beliefs about its function within football.

Cascio and Luthans (2014) draw on first-hand accounts of warders and prisoners to describe how Robben Island changed from a traditional oppressive prison to one positively orientated towards the prisoners during South African apartheid. The authors found that disruption was caused by several factors. Constant negotiation between the prisoners and warders (and the prison authorities) taught the prisoners about the strengths and weaknesses of the regime they sought to destroy. They used this knowledge to chip away at the moral foundations of the system. This was supported externally by the International Committee of the Red Cross and high-profile demonstrators campaigning for change. Cascio and Luthans (2014) argue that the prisoners dissociated the moral foundations of the prison by changing the mind-set of the warders (mainly white men). Their perceptions of the prisoners changed from being Black terrorists to fellow South Africans. At the same time, the core assumption that the prisoners were terrorists changed as warders gained an appreciation of the prisoners' cause and beliefs.

Finally, Styhre (2014) describes the disruption that had to occur in the Church of Sweden with the introduction of female priests. The challenge to moral foundations and beliefs of the church was based on the argument that there were no differences between men and women ministers in terms of theology and how they did their work. Slowly the argument was accepted and change took on a new momentum with the increased number of women priest and the retirement of many opponents.

In all these examples, the disruption of existing institutions involves the creation of new institutional frameworks. Suddaby et al (2013) argue for a need to pay serious attention to the subjective ways in which actors' experience institutions. By focusing attention not on the social structures that are the outcome of institutional processes but rather on the processes themselves the concept returns to its roots in phenomenology. Research can then investigate the differences between how an organisation articulates how they behave and how they explain their behaviour compared to how the actors behave and what they experience. The concept of institutional work provides a concept to understand the experiences of ESP.

Lawrence and Suddaby (2006) argued that the concept of institutional work can be applied at the individual level. Yet the examples in their original paper focused on national change in large organisations. Similarly, Lawrence et al (2011) suggest that studies of institutional work can and should focus on the lived experiences of individuals but provided few tangible examples. Kraatz (2011) contends this is unfortunate, as institutional work would be much more persuasive if it included compelling practical and humanistic reasons, and richer and

more evocative instances, of the empirical phenomenon. Empson, Cleaver and Allen (2013) critically argue that the weakness in the typology of institutional work is the lack of studies focused on individual endeavours. In the following section, the literature on individuals engaged in institutional work, or examples of the application of institutional work, was examined. The argument is made that the concept of institutional work complements the research study in providing a means of understanding the experiences of ESPs and is consistent with a phenomenological methodology.

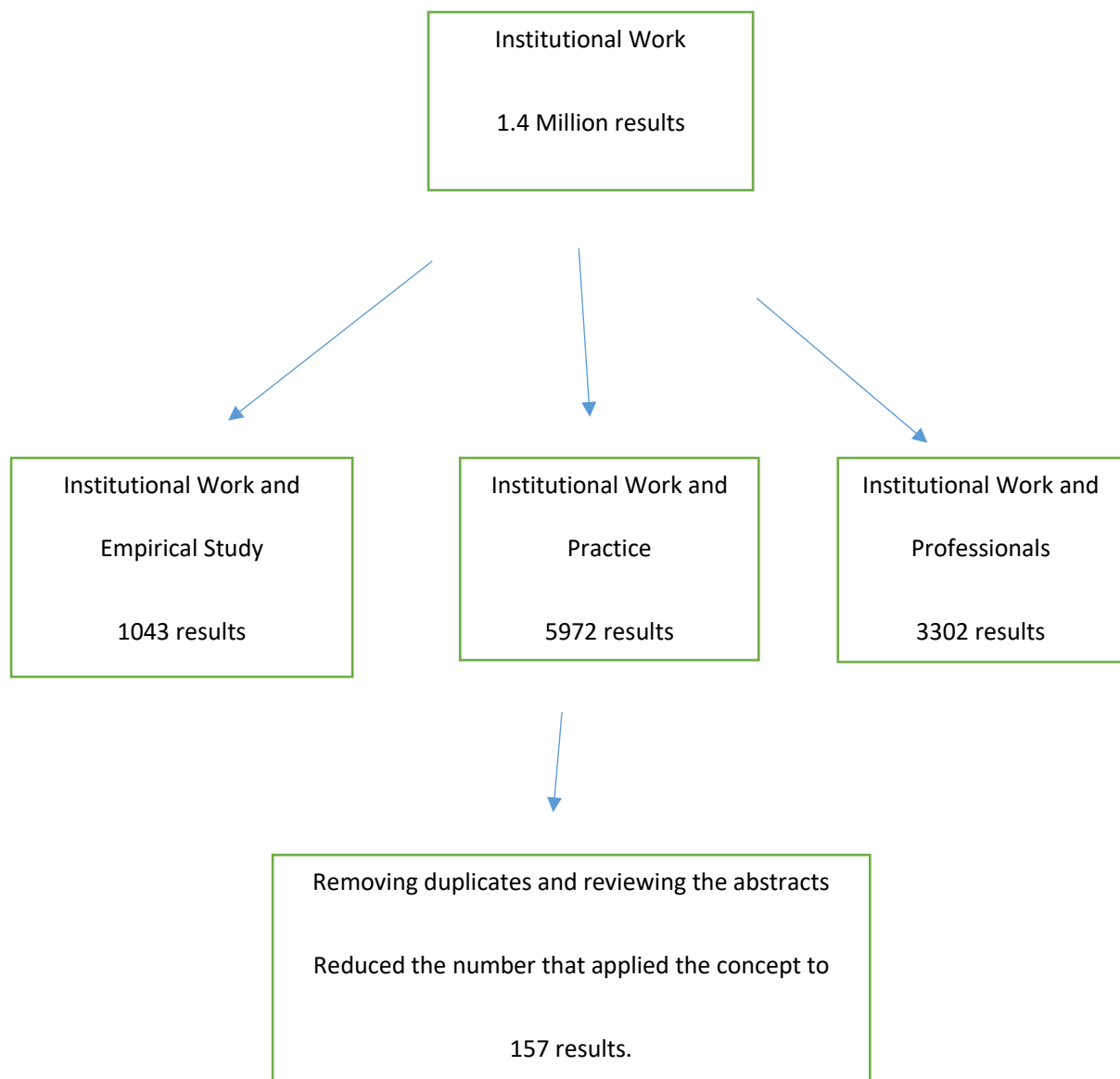
3.3.3. The Application of Institutional Work to ESPs as a means of Understanding their Experiences.

The ways in which professions gain, maintain and lose power has been a central issue in the sociology of professions and institutional theory (McCann et al 2013). The concept of institutional work, defined as “the purposive actions of individuals and organisations aimed at creating, maintaining and disrupting institutions” (Lawrence and Suddaby 2006 p215), in some ways reflects the earlier work of Abbott (1988) as described on page 23. The focus was on the attempts of individuals, or groups, to control the contents of their work or role and define a professional boundary which made them distinct from another profession.

The review of institutional work focused post 2006 following the introduction of the concept (Lawrence and Suddaby 2006) and continued until January 2017. The inclusion criteria were institutional work, professions and an application of the typology to the practice or individuals. Finfgeld-Connett et al (2013) identified that a challenge that all qualitative systematic reviewers face is that qualitative research reports can be difficult to identify using electronic indexing systems. This is because standard indexing terms for locating reports of qualitative research do not exist in the same way that they do for quantitative reports. This problem was made worse by the fact that authors of qualitative and mixed-method research reports appear to be particularly remiss about providing good descriptions of their research methods in the titles and abstracts of documents.

The following key terms produced the following results using the University of Huddersfield's research database.

3.3.3.1 Search Strategy



Adopting a meta summary approach established a hierarchy of evidence. Most references were excluded because they did not meet the inclusion criteria particularly the application of institutional work. Six papers detailed change in professional practice through institutional work. These form the basis of the literature review. Details of the meta summary are included.

3.3.3.2. Meta Summary Table (Example)

Institutional Work applied to the individual.

Hierarchy of Evidence

- 1) **Conceptual framework**
- 2) **Systematic review of qualitative studies applying Institutional work**
- 3) **Qualitative or quantitative studies of institutional work experiences**
- 4) **Expert opinion**
- 5) **Anecdotal opinion**

Author	Methodology	Strengths	Limitations
Muzio et al (2013)	Conceptional linking of Institutional work to sociology of professions.	Affirms the importance of studying professions as institutions and connecting professionalization to broader patterns of institutionalization. Provides a link to further studies.	Conceptual without application to practice. Code 1
Lawrence and Suddaby (2006)	Analysis of empirical research from 1999-2004 Arguing that three distinct categories of institutional work can be identified and explained.	Provides a concept to examine professional change and can be applied at the micro and macro level. However, the typology has not been applied to the individual. The focus of the empirical discussion is on macro-structures	The application of the theoretical concept may be an over- simplification, Lawrence and Suddaby (2006) have made a start by integrating insights from multiple empirical studies and have identified 19 forms of institutional work. Code 1
Lawrence et al (2011)	Potential application of the concept	“How individual actors contribute to institutional change, how those contributions combine, how actors respond to one another’s efforts, and how the accumulation of those contributions leads to a path of institutional change’ (p. 55). In other words, Lawrence et al.(2011)call for a detailed empirical analysis of the micro-dynamics of institutional work, focusing on the actions of individual actors	Doesn’t explain how it can be applied. Code 4

		within organizations as they engage in institutional work, and examining how the accumulated actions and	
Adamson et al (2015)	<p>Snowball sampling. Project draws on 19 in-depth, semi-structured interviews with senior executive remuneration consultants in the UK. Interviews were recorded and transcribed and then analysed by two authors. The data were also triangulated with supplementary sources such as consultation paper, Code of Conduct, review of the Code, RCG governance framework, and firms' documentation related to executive remuneration advice (e.g. ERC-related press releases, participant firms' codes of conduct statements).</p> <p>it strengthens the empirical foundations of the institutionalist approach to understanding professionalism</p>	<p>It strengthens the empirical foundations of the institutionalist approach to understanding professionalism the potential to produce a more nuanced understanding of the internal dynamics of the ERC professionalization process and its role in reconfiguring broader institutional arrangements.</p> <p>Application of Lawrence and Suddaby's (2006) conceptualization of the forms of institutional work involved in the creation, maintenance, and disruption of institutional arrangements.</p> <p>Points out that the typology is based largely on an analysis of studies that mainly examine the macro level of creation, maintenance, and disruption of institutions. Analysis suggests that some strategies of institutional work of creation, indeed, lend themselves better to macro level analysis</p>	<p>Similarities with McCann et al (2013), the same group of senior professionals exhibited contradictory strategies of creating and undermining the new project simultaneously: whilst strategically implementing various features of professionalism.</p> <p>On the contrary the CSP and participants have same agenda.</p> <p>Not set in healthcare.</p> <p>Code 3</p>
Currie et al (2012)	In-depth case study, including archival data, interview data and field notes developed	In-depth case study, including archival data, interview data and field notes developed through observation. Over 200 hours of field observation. Three of the	Based on the institutional work of powerful actors maintaining their position in the face of change rather than marginal

	<p>through observation. Over 200 hours of field observation. Three of the authors could sit in on events and meetings organized by Department of Health, Macmillan Cancer and project teams, and observe clinical practice in each of the comparative cases. Observations helped frame the interview schedule, and elaborate upon emergent analysis. 149 interviews with 105 key stakeholders across the 11 in-depth cases, plus 5 further interviews with external stakeholders.</p>	<p>authors could sit in on events and meetings organized by Department of Health, Macmillan Cancer and project teams, and observe clinical practice in each of the comparative cases. The authors sought to draw out illustrations of institutional work, but without explicitly invoking the concept in the interview, nor did they seek to ask questions that related to any particular category of institutional work; to reiterate our earlier statement, we allowed any category of institutional work to reveal itself.</p>	<p>actors wanting to bring about new change.</p> <p>Code 3+</p>
Empson et al (2013)	<p>Empirical study including observation, document scrutiny and interviews.</p>	<p>Strengthens the empirical foundations of the concept of institutional work, bringing together the various strands.</p> <p>Describes how individual professionals engage in institutional work to transform the institution of the professional partnership.</p> <p>Key types of work described.</p> <p>Undermining assumptions and beliefs, advocating, constructing identities, mythologizing, policing, and enabling/vesting.</p>	<p>Not set in healthcare.</p> <p>Management consultants who were employed to bring about change rather than embedded participants already in an organisation.</p> <p>Code 3</p>

McCann et al 2013 UK	Ethnography methodology Field observations and in depth interviews	Identifies pressure outside of the profession eg targets. Shows how individuals resist change to maintain their professional position.	Work was on maintaining rather than change. Code 3-
Canning and O'Dwyer (2016) Eire	Documentary data analysis and in-depth interviews. Coded using the typology of institutional work	Revealed a more refined, nuanced categorisation of institutional work within efforts to instigate regulatory change. Showed how specific forms of institutional work interact and mutually reinforce or displace one another as regulators seek to establish power and legitimacy in a regulatory field.	Powerful actors in powerful positions bringing about legislative change. Some relevance Code 3-
Hayes and Free (2014) North America	15 in-depth semi-structured interviews with 13 individuals from various locations in Canada and the United States between May 2010 and September 2012	empirical observations contain no evidence of disconnecting sanctions/rewards, policing, and deterring forms of institutional work, noted that mimicry and mythologizing share significant overlap in their definitions and that institutions rise in part because of prior related institutions Drawing on a range of interviews with key stakeholders and an analysis of secondary materials, they found evidence of numerous forms of institutional work including theorizing, rhetorical appeals, mythologizing, constructing normative networks and educating.	Focused on accountancy and changes within the profession. Concluded that theoretical work in institutional work remains relatively nascent. Further studies required to refine and consolidate the theoretical categories and concepts in the area. Code 3

3.3.3.3 Application of Institutional Work to the Individual

The following studies used parts of the Institutional Work concept to explain the experiences of professional engaged in change. Currie et al (2012) examined the institutional work carried out by elite professionals to maintain professional dominance in the face of external threats to their position. They examined the organizational changes associated with the Main Streaming Genetics (MG) initiative from 2004 to 2008. Prior to the launch of the MG initiative, genetics services were carried out by specialist clinical geneticists (supported by genetics counsellors) located in a tertiary care centre, irrespective of whether the patient was low, medium or high risk in terms of genetic concerns. However, worries about the expense, availability, distances for patients to travel and inequalities in services provided prompted the Department of Health to promote the main streaming of genetics knowledge and service into secondary care and primary care.

Drawing on 11 case sites Currie et al (2012) conducted 149 interviews with 105 key stakeholders. These interviews explored a range of issues relating to wider organizational changes associated with MG, focusing on questions about who drove or resisted change, when and how change was driven or resisted, and with what consequences. They focused on the work of Medical Geneticists (specialist consultants) and the way they responded to new nursing or medical roles being introduced which threatened their power and status as specialist doctors.

The Medical Geneticists actively engaged in the change process but in ways that controlled the direction of change and maintained their clinical position. Currie et al (2012) describe distinct types of activity which align with the institutional work typology. In particular, how the clinical geneticists used 'theorizing' and 'defining', as a means of maintaining institutional arrangements. Specifically, the geneticists raised concerns of clinical risk and present themselves as 'arbiters of risk'. to make the case for why the delivery of genetics services might be delegated, rather than substituted. They claimed to be able to mediate risk through tacit knowledge, which was based upon their extensive formal education and experience. Building upon the argument that the proposed institutional changes were risky, and they were best placed to mediate risk, enabled them to engage in 'defining' their role and the role of others. In doing so they ensured that work was delegated and they maintained supervision on other clinicians. They created a theory or myth that they were best placed to manage risk.

Further, the clinicians maintained their role 'educating' the new role-holders in the skills and knowledge to support delegation of the delivery of genetics services. As highlighted by Lawrence and Suddaby (2006), the relationship between education practice and control mechanisms is a strong one. At the same time as providing the education, the geneticists

'policed' the new role-holders, ensuring compliance to the rule system through enforcement, auditing and monitoring. Currie et al (2012) highlighted that 'theorizing', 'defining' and 'educating', originally linked to institutional creation by Lawrence and Suddaby (2006), were types of institutional work enacted for institutional maintenance. Distinct types of institutional work interacted and mutually supported each other. Currie et al (2012) concluded, that maintenance work was less about change resistance, and more about positive action to shape the change trajectory to ensure continued professional dominance.

Currie et al (2012) identified a weakness in the concept of Institutional work in terms of a discrete or progressive step wise typography but they did demonstrate how the individual work streams could be applied to the work, and experiences, of practitioners engaged in change, or subject to change in the workplace. McCann et al (2013) also used the concept of institutional work in a study of UK paramedics to uncover that the agency of individual workers may be more significant than the collective efforts of a professional body in shaping the development of the profession.

The College of Paramedics (the recently established UK professional body of paramedics) has advocated strongly for a professional framework. There had some success in terms of training and certification in higher education with the introduction of paramedic degrees, research journals, codes of practice and a professional body. However, McCann et al (2013) identified, through their ethnographical methodology using field observations and in-depth interviews of paramedic staff and managers, that little had changed in frontline practical experience of work. The most powerful influence on paramedics was the ambulance trusts that employed them. Short term priorities such as hitting targets and winning and maintaining care contracts were more important to NHS trusts than any aspirant long-term project such as paramedic professionalization. The response of the paramedics was to engage in institutional work focused on maintaining their status and identity in the workplace rather than institutional change on a national scale. This mismatch between the formal senior level entrepreneurs in the College of Paramedics and the "street level institutional work of the paramedics" (McCann et al 2013 p772) maintaining their role had an ambivalent effect which served to reinforce the traditional modes of acting of ambulance crews.

In other words, the organisation had the greater impact on the paramedics' experiences. The agency of the ambulance staff was focused on delivering the objectives of the organisation and in doing so maintaining their status quo within it. In contrast, Empson et al (2013) provided a detailed account of how newly created management consultants implemented change in several international law practices in the City of London. The emphasis of this study identified how new actors into an organisation worked to produce change in the organisation which

established the remit and status of the new role and its relationship to existing actors in the organisation.

Using interviews, observation and access to corporate documents and minutes, Empson et al (2013) examined how the firms changed from a traditional partnership structure, in which the emphasis was on diffuse authority and individual autonomy, to one with a hierarchical governance structure, stringent partner performance measurement and management systems. Empson et al (2013) concluded that, contrary to Lawrence and Suddaby (2006) suggestion, forms of institutional work did not follow a clear sequence of stages reflecting the life cycle of institutional change (i.e. creating, maintaining, and disrupting the institution). Empson et al (2013) identified the simultaneous occurrence of a variety of forms of institutional work which encompass all three stages. Similar to the findings of Currie et al (2012) the typology of institutional work was useful in describing the experiences and work of individuals engaged in change but the processes of creating, maintaining and disrupting institutional arrangements were more inter-dependent and occurred within a matrix of activity rather than a linear work programme.

For example, Lawrence and Suddaby (2006) originally argued that, for institutions to be disrupted, key actors must undermine core assumptions and beliefs about the risks and costs associated with innovation and differentiation. However, Empson et al (2013) found this to be a much more gradual process and linked to the establishing and maintaining the new role. Existing beliefs were not so much overtly challenged but innovative ways of working were shown to be better. The management professionals firstly advocated their role robustly with directors outlining the benefits of new ways of working. In doing so they gained the support of senior managers but more importantly this support, as uncovered in interviews, was seen by other staff as legitimizing the changes. Advocacy, rather than being used to create a new institution, was being used to disrupt an existing one. The new management professionals through negotiating a relationship with the managing partners agreed delegated tasks that they would be responsible for delivering (i.e. the management consultants defined their role and status). The result, as viewed by others within the organisation, was they were perceived as a deputy for the managing partner, rather than a servant carrying out orders. From this position, the relationship with the other partners became that of a peer and junior staff became under their direct remit.

Through establishing these relationships, the management consultants created an identity for the role relative to other actors within the field. Empson et al (2013) in interview with the management consultants uncovered a rhetoric based on the institutional work of valorising and demonising. In particular, the use of exaggeration to emphasize how 'bad' things used to

be before they rose to prominence in the firm and how much better it was since they had arrived. In doing so the management consultants were developing a myth and history around the role. The past was actively demonized but the present and future change was valorised. The reason for this success was due to the management consultant, or so the rhetoric of the consultants would have you believe. The management consultants consolidated their position within a newly formed hierarchy using a rhetoric focused on adapting and making ready the firms for the future. Institutional change occurred by disrupting the old institutional logic while simultaneously creating a new one but it also by maintaining parts that were of benefit to key actors.

All three stages of institutional work accounted for the gradually emerging institutional logic of corporatized partnership at the expense of the established traditional partnership. In other words, while the three stages of institutional work may be analytically distinct, in the real world of change all three occur simultaneously. The theoretical literature presents abstract categories of institutional work which have been derived from various empirical studies but not yet systematically applied to individuals in the workplace. "Whilst analytically elegant, the concept of institutional work presents certain challenges in terms of trying to contain the world of practice into discreet domains" (Empson et al 2013 p837). This and several other studies suggest an overlap and integration of the several types of work and a concept in development rather than completion. However, the work of Empson et al (2013) demonstrates how the concept of institutional work can be applied to the experiences of individuals to provide an understanding of what is occurring at the individual level and organisational or institutional level.

Three other studies demonstrated how the concept of institutional work can be applied to individuals engaged in change in the workplace. All show how the concept provided a language, or framework, to explore individuals' experiences but also highlighted the development and refinement of the concept through its application to workplace situations. Hayne and Free (2014), examined the emergence and diffusion of enterprise risk management within accountancy practice in Canada. Similar to previous studies there was scant evidence of the neat sequential categorisation suggested by Lawrence and Suddaby (2006). Instead, their analysis implied a more fluid, non-linear process whereby "certain forms of institutional work persisted, others disappeared, while others in turn re-emerged" (Hayne & Free, 2014, p.326) thus indicating how individual actors can skilfully combine several sorts of institutional work. They concluded that what is important to our understanding of the efforts that individuals engage in as they seek institutional change is not which form of institutional work comes first, but rather how one form of institutional work can enable and support other forms.

Adamson et al (2015) applied institutional work to the way Executive Remuneration Consultants (ERCs) established their role. The UK government, through company law, defined the remit of ERCs as professionals providing independent advice on executive pay. The creation and responsibility, established through legislation, forced the acceptance of these roles in large companies. Using semi-structured interviews Adamson et al (2015) focused on how the ERCs maintained their role in company.

The ERCs came from varied professional backgrounds (law, HR, management) and many of the interviewees were more comfortable being associated with their previous profession than the new one. This was compounded by the lack of an ERC professional association based on individual subscription. Membership was corporate with firms committing to the professional association and its code of conduct rather than the individual ERCs. Adamson et al (2015) suggest that this lack of individual commitment to a professional body explains why each ERC role was different and moulded in response to pressures and demands within the organisation. The individual practitioners implemented their own interpretation of the role influenced more by the clients and firms they worked for rather than their professional association. This lack of a strong professional identity, and normative network to support the individual, created a vacuum. Such findings have some resonance with the physiotherapy literature with ESPs developing in response to local needs and the enthusiasm of practitioners (Kerstein et al 2007; Stanhope et al 2012). Further, like the findings of McCann et al (2013) the ERCs were influenced and moulded by the institutional arrangements of the organisation and not the newly established profession.

Canning and O'Dwyer (2016) focused on the lived experience of individuals seeking institutional change in the regulation of accountants, in Ireland, and applied the concept of institutional work to theorise these efforts. Interviewing and observing senior board members, and taking account of the powerful influence of the state, they concluded that the three-stage categorisation of institutional work lacked the nuance necessary to illuminate the inherent complexity of individual actors attempting institutional change. Similar to previous studies highlighted in this review the sequence of institutional work depended on context and the actors involved.

As examples, Canning and O'Dwyer (2016) found that the educating work undertaken by the chairman ensured that the directors had a sense of clarity and commitment regarding their roles. Advocacy work with Government officials aimed at mobilising their support, contributed to the work of constructing normative networks. Audit (policing work) was undertaken in the creation phase rather than in the maintenance phase. Advocacy, work which Lawrence and

Suddaby (2006) associate with the creation of an institution, was prevalent in the disruption at the beginning and end phases as well as in the creation.

It appears from these applications of the concept that forms of institutional work often occur simultaneously with the analytical distinctiveness outlined by Lawrence and Suddaby (2006), not always according with the empirical reality. However, what these studies also demonstrated is that the concept of institutional work provides a framework to explore the experiences of individuals within an institutional context. It enables the links between a profession, the workplace and other professions and the individual engaged in changing practice to be explored and a means to understand the experiences of change.

3.4. Summary

The literature reviews identified that there is little understanding of the experiences of physiotherapists working as ESPs. The first limb of the research question aimed to address this lack of knowledge. The studies on institutional work illustrated how the concept can explain these experiences in terms of the purposeful activities and processes of professionals. The studies of institutional work have focused on those in powerful positions (Curry et al 2012, Hayne and Free 2014, Canning and O'Dwyer 2016), new individuals with new roles introduced into the field (Empson et al 2013, Adamson et al 2015) or professionals working against their own profession (McCann et al 2013). In contrast, the focus of this thesis was on ordinary physiotherapists not in a position of power working in line with a professional agenda. Suddaby (2010 p17) concluded that institutional work "is conducted by individuals and it is somewhat surprising to me how individuals often disappear from institutional research." Going further, Lawrence et al (2011) argue that missing from the accounts of institutions is the daily activity of individuals that bring about change.

Suddaby et al (2013) contend that by focusing attention not on the social structures that are the outcome of institutional processes but rather on the processes themselves the concept of institutional work returns to its roots in phenomenology. Research can investigate the differences between how an organisation articulates how they behave and how they explain their behaviour compared to how the actors behave and what they experience. There is a need to pay attention to people and what they do and experience to understand how macro organisations work.

Using a phenomenological methodology this study gains an insight into institutional work, through the voices of individuals as they engage in institutional change, and professional work within an organisational context. The concept of institutional work provides a means to

understand the 'lived experience' and how this connects with the institutions that structure and are structured by these experiences (Lawrence et al 2011). Applying the concept provides a means to understand the experiences of the ESPs and the opportunity to refine the typology. It also provides a common template to examine the institutional work of the individual and the physiotherapy profession.

Chapter Four: Methodology

4.1 Introduction

This chapter discusses the underpinning philosophy of the methodology and analysis. It rationalises the choice, discusses the criticisms and limitations of the methodology and the ways these have been addressed. Finally, it describes how transparency and reflection are incorporated into the research process.

The methodology needs to be congruent with the research question and purpose of the study (Carpenter and Suto 2008) and underpinned by philosophical and theoretical ideas which direct the data captured, how it is used and how it is reported (Finley 2006). The research question aims to uncover and then to understand the experiences of ESPs. Qualitative research methods enable researchers to delve into questions of meaning, examine institutional and social practices and processes (Starks and Brown-Trinidad 2006). The research framework chosen provides an analytic approach that aligns the aim and objectives of the study with the researchers' assumptions, existing knowledge, and reasons for engaging in research.

Several methodologies were considered: discourse analysis, grounded theory and phenomenology and assessed in terms of the aim of the study and the audience. Starks and Brown-Trinidad (2006) argues that although the approaches have similarities in the analysis of data, in terms of a process of decontextualizing and then re-contextualizing data, they are different from their starting position and the way in which the research findings are framed and packaged for the audience. The choice of methodology was guided by the research question and the aim of understanding the experience of being an ESP.

Discourse analysts explore how knowledge, meaning, identities, and social structures are negotiated and constructed through language (Starks and Brown-Trinidad 2006). The products of discourse analysis use evidence from participants' narratives and other texts to expose the ways in which people use language to accomplish their objectives (Grue 2015). Grounded theory is a systematic procedure used to generate a theory, from the data collected that explains a process at a conceptual level. The intent of grounded theory is to use deductive and inductive reasoning to formulate hypotheses based on conceptual ideas (Cresswell 2013). Neither of these approaches address the aim of understanding the experiences of being an ESP.

Phenomenologists ask questions about lived experiences, as contrasted with abstract interpretations of experience or opinions about them (van Manen, 1990). Such accounts allow the reader to get a feel for what it is like to have the experience, aids understanding and insight into those experiences influence practice. There is little knowledge about the experiences of ESPs from academic papers or understanding of how the roles developed and adapted in the workplace. The aim of the study was to capture the experiences of ESP to try to gain an understanding of what it was like, by making sense of, what and why ESPs were doing. Phenomenological approaches are based in a paradigm of personal knowledge and subjectivity, and emphasize the personal perspective and interpretation. As such they are strong methods for understanding subjective experience, gaining insights into people's "life world" or lived experience Langdrige (2006) and uncover the common meaning from several people of a lived experience (Creswell, 2013).

Within the phenomenological tradition there are two variants: descriptive and interpretive. Pure phenomenological research aims to describe rather than explain (Parahoo 2006). Interpretative or Hermeneutic phenomenology "attempts to understand the interpreted structures of experience and how we understand others and ourselves in the world around us" (Langdrige 2006 p 109). By recalling events or experiences they are turned into objects of consciousness which can be re-examined (Cresswell 2013). Themes or patterns which are identified in the subjective experiences uncover the complexity of the social processes. Rather than being guided by theory, phenomenology seeks to describe and interpret lived experience, then relate the findings to existing theory (Smith et al 2009). Further, interpretative phenomenological approaches are often about identity and role because "individual accounts of significant experiences or events almost always impact on personal or social identity" (Smith and Eatough 2007p39). For these reasons, the study took an interpretative phenomenological methodology.

4.2 Interpretative Phenomenology

The essence under investigation is the experience of being an ESP in an acute hospital. Gadamer (1976 p60) argues that language is the essential way in which understanding emerges, "what is not present manifests through speaking so that another person sees it." Language is the means through which consciousness connects with others. For Gadamer, all existence is not reducible to language but all interpretative understanding of existence comes through language. There is a theoretical commitment to the individual as a cognitive, linguistic affective being and an assumed chain of connections between people's talk and their thinking and emotional states (Smith and Eatough 2007). The aim is to transform lived experiences into textual expressions of its essence in such a way that the effect of the text is at once a

reflexive reliving and a reflective appropriation of something meaningful (Van Manen 1992 pg36).

The interpretative phenomenological approach has two viewpoints. One advocates “bracketing” or suspending the researcher’s own preconceptions, beliefs or prejudices so that they do not influence the interpretation of the respondents’ experience (Parahoo 2006). The alternative argues that the researcher is not separated from the world. In comprehending the lived experience, it is not possible to suspend completely or “bracket” one’s own experiences out of the process (Langdridge 2007). This needs to be accepted and made explicit as part of the process.

The philosophical basis of the methodology and subsequent method and analysis follows the Heideggian position in that to fully comprehend the lived experience of another person is in essence an interpretation process and that bracketing out pre-conceptions is neither possible or desirable. On a practical point Tufford and Newman (2012) point out the challenges of bracketing in qualitative research as to establishing how, when and where it is used and to convince the reader that it has occurred. In contrast, the premise of this research is that the researcher is implicated and part of the new understanding. The researcher is part of the study rather than external to it. The ontological position taken is a realist stance which maintains that the world is made up of structures and objects have a cause-effect relationship with each other. Phenomena are seen to be made up of essential structures that can be identified and described (Finlay 2006). The researcher can understand the participants in a certain way because of pre-understandings and these pre-understandings are in turn influenced by the experiences of the participants to create a new understanding. As Gadamar (1976 p94) describes it this new understanding “allows the foreign to become one’s own, not by destroying it critically, or by reproducing it uncritically, but by explicating it within one’s own horizons with one’s own concepts and giving it new vitality.”

Van Manen (1992) argues that objectivity can be maintained by being true to the object being described and interpreting without being misled or side-tracked. The emphasis is on being transparent and open with the reader and allowing them to judge how the text was used to identify themes, understand their meaning and give an insight into the experience. Understanding is made possible by grasping not only what the text says but also drawing attention to the ways perceptions and experiences are socially, culturally, historically and linguistically produced (Finlay 2006). The situation and context influences understanding. This is a dynamic process in which participants try to make sense of their world while the researcher tries to make sense of how the participants are making sense of their world (Polit and Beck 2010). In interpretative phenomenology, this is described as a process of “double

hermeneutics.” The researcher accommodates the participants’ interpretations of their experience but also make their own interpretations of participants’ interpretations. It is an attempt, as far as possible, to gain an insider perspective of the phenomenon being studied, whilst acknowledging that the researcher is the primary analytical instrument. The researcher’s beliefs are not seen as biases to be eliminated but rather as being necessary for making sense of the experiences of other individuals (Smith et al 2009).

Smith and Eatough (2007) describe the relationship between the researcher and participants as a combination of empathetic hermeneutics, in trying to understand what it is like from the point of view of the participant, and at the same time standing back and asking curious questions in a critical hermeneutic framework. It is the balance of moving between the rich experiential descriptions of the participants and developing a more interrogated alternative account. The outcome of this critical reflection is to allow themes that emerge to become one's own.

Reflexivity is an integral part of the research process but there is a philosophical tension between those who believe that looking beyond preconceptions is possible and desirable and those that reject the notion of a capacity to bracket out preconceptions (Tufford and Newman 2012). It has been argued that the lived experience is an interpretation process and that to be completely free of prejudice is naïve (Gadamer 1972 pg93). There is a need to recognise these preconceptions through attention to detail and reflection on actions and intentions. The task of Hermeneutics is the bridging of the personal and historical distances between minds (Gadamer 1964 pg95) and to describe and understand this as a coherent picture.

Analysis is discovery as well as construction. The results are not known in advance nor tested in the study, but emerge from interview transcripts, constructed in an iterative way from the voices of the participants. During the analysis, there are two subsets of interpretive processes: making sense of meaning and experiences of the participants by reducing the content of transcripts into themes, and secondly interpreting or explaining those results in the context of relevant scholarly literature. The methodology is based on the art of writing and rewriting allowing internal thoughts to be fixed on paper so that by staring at what is written a “reflective cognitive stance” can be achieved (Van Manen 1992 p125). It provides a distance from the lived experience from which to view it and may suggest a structure to that experience. By writing, reflecting on the text and rewriting the essence of the phenomenon emerges which can be described and understood. This creative process teases the themes from the data and allows it to be viewed and interpreted in the social and historical context in which it was captured. Van Manen (1992) is clear, it is the writing and rewriting of a narrative which is the

methodology. The cognitive activity of writing, reflecting and creative rewriting all fuse to create the understanding of the experience and the interpretation of the experience.

4.3 Criticisms of the Methodology (Reflexivity)

In taking an interpretative phenomenological approach, it is prudent to be aware of the criticisms levelled at the methodology and to consider ways of addressing them. One fundamental concern centres on how the researcher can know if their understanding or explanation is consistent with that meant by the participants. The argument centres on the difficulty determining which aspects of an account are what the participant thinks and which parts simply reflects what the researcher prompted the subject to say. As Silverman (2009) comments there is a danger that information and accounts are not uncovered but are simply created by the research or the researcher.

Lyons (2007 p22) contends that the outcome of phenomenological research is a “result of a dynamic and inescapable interaction between the accounts offered by the participants and the interpretative framework of the researcher.” By acknowledging this, and providing a transparent methodological account, which articulates my role, a critical stance towards the research and the interpretation can be taken by the reader. James et al (2010), in defending the phenomenological methodology, argue that openness and constant reflection during the process turns pre-understanding into a deeper understanding of the phenomenon under investigation rather than becoming an obstacle to seeing something new. The researcher's own ways of thinking, and perceptions, in making sense of another person's experiences, can produce knowledge which is reflexive by acknowledging and not hiding the researcher's own standpoint. In doing this the interpretation of the participants' experiences can be considered alongside the researcher's prejudices to establish if the impact accords with the participants' descriptions of experience and whether the interpretations and insights evoke recognition and understanding in the reader (Todres and Holloway 2006). The process recognises that I am co-producing knowledge in stark contrast to the detached observer in search of an objective truth (Langdridge 2007).

Norlyk and Harden (2010) contend that interpretation stems from the participants' narrative but there remains a tension between the openness to the text and criticality of what is being said or implied. There is a balance between the participants' and researcher's perspectives. Reflexivity, as critical self-reflection, focused on the researcher's background, assumptions and behaviour before, during and after interacting with the participants ensures that the

emphasis is on their experiences. By making this process explicit it allows the reader to challenge how the researcher may have affected the research process (Finlay 2006).

Langdridge (2007) argues that central to understanding is self-understanding because we are influenced by our history and culture. Reflexivity, in this context, is an invitation to think about how one's reactions to the research context and the data make possible certain insights and understanding. Probst and Berenson (2014) provide two points to consider when discussing reflexivity. First, is a temporal dimensional in that, reflexivity can be embedded in the moment, concurrently, as well as after the moment has passed, retrospectively. Secondly, reflexivity must create some sort of change, since when we are questioning ourselves and our position in the world it leads to questions about the world itself and our knowledge of it. This change in perception needs to be identified within the research.

As reflexivity is a crucial part of the methodology it seems appropriate to reflect on reflexivity. Several concerns have been raised in the literature. First, and most common, is that by focusing on the researcher's internal processes it shifts attention away from the people or phenomena being studied. While scholars agree that reflexivity needs to serve the research agenda and not the other way around, there are no clear guidelines for assessing how appropriately reflexivity has been used. The line between utility and indulgence may not be evident to the researcher, especially if working alone (Probst and Berenson 2014). Access to one's motivations, preferences, and aversions may not be as simple or obvious as the notion of reflexivity implies. Experience of discomfort can leave a researcher in a quandary or a position of vulnerability. It is only over time on this research that I have become a little more comfortable with the process. What I have kept in mind is that this is a learning journey and an opportunity to engage in something new and challenging. However, it is only at the end of the process, when the study is in the public domain that others will judge its probity in terms of the method and outcome. Further, it is not clear whether reflexivity produces better research. Pillow (2003) cautions against assuming, that just because we are reflexive, our work is truer, better, more valuable or authentic. Reflexivity is not, she points out, a cure for the problem of representing someone else's reality. Finlay (2002) makes a similar point. A researcher's apparent self-disclosure can mask the inevitably partial nature of the research findings, just as seemingly transparent discussions of positioning and co-construction can be used to justify unmerited claims of credibility.

A second criticism of the methodology is that participants may not describe their experience. As Gadamer (1972) points out spoken language can be used to knowingly conceal. The participants may choose not to describe an experience or describe it in a certain format which alters the description for a reason such as embarrassment or modesty. Van Manen (1992 p78)

notes that participants in hermeneutic interviews often invest more than a passing interest in the research project in which they willingly involve themselves. "They care about the subject and the research question." Cronin-Davis et al (2009) argue that by ensuring that participants are fully informed about the nature of the conversation and the phenomenon being studied they have a willingness to share their experiences. This needs to be clearly articulated in the design of the study and the information given to participants (Appendix 3 and 4).

Todres and Holloway (2006) maintain that the findings from a good phenomenological study have a resonance that individuals identify with or it creates an understanding about the differences from one's own experiences. The results should provide enough detail for the reader to assess the relevance and applicability of the findings. The narrative needs to demonstrate the fit between the data and the interpretation in a coherent and integrated way while preserving the nuances of the data (Willig 2004). In being aware of these criticisms of the methodology and addressing them during the research journey, the interpretative phenomenological approach and the philosophical stance behind it, provided a framework to reach an understanding of the experiences of physiotherapists working in extended roles.

Phenomenological research is fundamentally a writing process to create a text which describes the structures and meaning of lived experiences from the transcribed texts of participants. The philosophical approach does not encourage a pre-occupation with method or technique but van Manen (1992) suggests a set of recommendations which allow a dynamic interplay between the research activities. These do not challenge the tradition of being supposition less, the desire not to create a pre-determined set of procedures and rules which would govern the research project, but they do provide a framework. These are discussed in the next chapter which details the method.

Chapter Five: Method

5.1 Introduction

In this chapter the practicalities, challenges and frustrations of the study are discussed. The sections follow the stepwise process of gaining research approval, ethical issues, selecting the participants, the interview process and reflections on the experience. The analysis of the text and the identification of themes are then discussed. Throughout the chapter my involvement in this process is considered and critically reviewed.

In September 2010, I was head of physiotherapy and chair of the regional physiotherapy senior managers group which met quarterly to discuss professional issues. I took the opportunity to discuss my research proposal with fellow managers and ask for their support subject to ethical and hospital approval and their formal consent at a later stage. These conversations reinforced my initial thoughts about the variety of roles and the lack of understanding about how practitioners were delivering and developing their practice. Initiating the conversation with managers highlighted the differences that were occurring in each hospital. Each acute hospital had ESPs working to different clinical remits, in a variety of specialities and each role appeared to develop in isolation from neighbouring hospitals. The creation of these roles appeared to stem from demands to meet waiting times for patients' first appointments and the availability of an individual with the clinical enthusiasm to practise in that area.

My own perceptions and experiences of ESPs were of ambitious and motivated experienced clinical physiotherapists looking for greater job satisfaction by learning and practicing new skills. The focus was on being able to do more, or offer more, in their contact with patients by acquiring the skills of a consultant rather than the skills of another profession such as nursing. In many cases this involved the ESPs moving outside of the physiotherapy department and into consultant clinics where their development and experiences were invisible to "ordinary" physiotherapists working within physiotherapy departments. This was a gradual and

incremental morphing process as the ESP acquired new knowledge and new skills. What struck me was that the context of practicing these new skills and knowledge was context specific i.e. the consultants` clinics rather than generic within physiotherapy practice and patients referred to physiotherapy. Little was known of the process or the experiences becoming or being an ESP. The CSP (2010) were advocating such roles but there was no template or pathway to create such roles and most appeared to be driven by individuals pursuing a change in clinical role which befitted both them and met service demand.

5.2 Ethical Approval and Informed Consent

The proposal for the study considered the ethical issues of: consent, anonymity, confidentiality and the nature of the power relationships between the researcher and the participants. This was particularly relevant as I was a physiotherapy manager. The application also considered any potential risks to participants. Briefly, consent addressed the need to ensure participants were fully informed, understood the information, were given sufficient time to reflect on their decision, and that the consent process, including any risks, were properly recorded (Parry 2010). The process undertaken is described later (p56). In research encounters, participants can feel vulnerable, despite their senior professional status, through emotional recall and retelling of their personal experience career development. Conversely, other researchers have noted the almost therapeutic effect that the presence of ‘an attentive and sympathetic listener’ can have in interviews with senior practitioners (Lancaster 2017). Therefore, it was made explicit that the participants could withdraw from the research study at any time without giving any reasons. In addition, as one practical way of reassuring participants and managing these sensitivities, participants were advised that they would be sent a copy of their transcript to review for the purposes of verifying accuracy, correcting errors or inaccuracies, and providing clarifications.

The concept of confidentiality is associated with anonymity, insofar as anonymity is one way of applying confidentiality by ensuring that individuals cannot be identified (Gibson, Benson.

and Brand 2012). Maintaining participants' confidentiality and anonymity was important due to ongoing partnerships and professional relationships between participants who may know each other and physiotherapy managers who may employ these ESP currently or in the future. By guaranteeing confidentiality to participants, participants were protected and more likely to offer richer descriptions and detailed accounts (Kay 2017). This argument also applies for not disclosing the hospitals that the participants were employed for fear of identifying the participants.

The issue of power is discussed separately in describing the relationship between the participants and the researcher in conducting the interviews (p62-63). The fact that at the time of ethical approval the researcher was a senior physiotherapy manager was considered in the original research proposal. However, this potential hierarchical power situation at the time of the interviews was not an issue because the researcher was no longer in that clinical position.

The study was initially submitted to the University of Huddersfield and approved by its research ethics committee. The proposal was then sent to the regional ethics committee (REC) where I appeared in person to answer questions about the research proposal. The REC approved the proposal subject to one significant change. They insisted that I could not contact potential participants directly. The participants could be given the information about the study and my contact details by their manager. It was then their decision whether to contact me for further information. The committee argued that in this way there would be no coercion by the researcher and the participants could decide freely to opt into the study (ethical approval letter Appendix 2),

With this agreed the research proposal was submitted to three research and development departments of acute hospitals for approval to conduct the study on their premises and contact hospital staff through the physiotherapy manager. The study was approved without further amendments. Next formal consent of the heads of physiotherapy was sought to conduct interviews with their staff as the interviews of prospective participants might occur during

working hours and on hospital property. They also needed to be fully aware of the nature and scope of the project and their consent was needed to support it.

The information supplied to the physiotherapy managers (Appendix 3) assured anonymity for the hospital but also explicitly stated that the conversation with practitioners was confidential and would not be passed on to managers. There was one caveat which was explicit in the information. This one exception related to disclosure during an interview of practice or concerns that might compromise the physiotherapy code of professional conduct in terms of safety or patient care. It was clearly stated in the information documents to physiotherapy managers and participants (Appendix 2,3) that such disclosures would be passed on through the professional lines of accountability. This would remain confidential and would be left with the physiotherapy manager to deal with appropriately. As all the participants, the researcher and the heads of physiotherapy were registered physiotherapists, this exception ensured compliance with professional standards and professional code of conduct (CSP 2002) which places an obligation on physiotherapists to report to the appropriate person any concerns about clinical practice.

5.3 Sampling and Recruitment

Phenomenological studies utilize homogeneous and purposive samples so that themes can be realised from certain groups of people who have shared experiences (Smith et al. 2009). Rather than being representative of the population, and including all perspectives, the sample explores the perspective of a group with similar characteristics or within a similar context (VanScoy and Evenstad 2015). Participants are recruited who can offer a meaningful perspective of the phenomenon of interest and who share a certain lived experience (Langdridge 2008). Small sample sizes are typically used because an individual person can generate hundreds or thousands of concepts (Tod 2006). Therefore, large samples are not necessarily needed to generate rich data sets in phenomenological studies (Smith and Eatough 2007).

Smith et al (2009 p52) contend that “it is important not to see the higher numbers as being indicative of ‘better’ work [...] Successful analysis requires time, reflection and dialogue, and larger datasets tend to inhibit these things.” Typical sample sizes for phenomenological studies range from 1 to 10 persons (Starks and Brown-Trinidad 2007). The research proposal for this study suggested 10 participants would be recruited based on suggestions in the academic literature (Morse & Field 1995, Gibson 2004, Todres and Holloway 2006, Smith et al 2009). These would be recruited from three hospitals to ensure the sample size.

The physiotherapy managers identified potential participants and sent emails to their staff with details (participant information sheet) of the study and my contact details. This had a two-fold effect: the first was that the participants were identified by the head of physiotherapy as acting in an extended role within the hospital. This removed any ambiguity about roles and definitions of roles. In this study, the extended scope practitioners were those practitioners identified by their professional head of physiotherapy as having additional skills and roles which they practised within the hospital as ESPs. The identification of these participants by the heads of physiotherapy created a closely defined group for whom the research question would be relevant.

The second issue, which could have had an impact on the research, was the potential that no participants would come forward. The study relied on participants actively contacting the researcher once the information was sent to them by their manager. The researcher had to wait for the participants initial contact and expression of interest. Fortunately, several potential participants contacted the researcher via email. These were individually replied to with a request to discuss the research via a telephone conversation at a time of their choosing. If the participant agreed the email was followed by a telephone call. Finally, if the participant was interested in taking part an interview date was then scheduled at a time to suit them. Initial contacts were made over a seven-week period and interviews were arranged around the participants` diaries.

Thirteen participants opted in to the research and twelve interviews were conducted over a thirteen-week period. One person originally arranged an interview but was unfortunately unwell on the day. She later contacted me and said she would arrange another date but failed to make contact again. In the spirit and guidance of the REC I did not pursue this participant for another interview date.

People can only make an informed decision when they have adequate information on which to make that decision (Holloway and Walker 2000) and so I took the time to outline the study. Ballinger and Wiles (2006) suggest that it is good ethical practice to share expected findings and possible outcomes with the participants to allow them to assess the benefits of taking part and any risks that could occur. The difficulty is that the findings of a qualitative research project can look different to what was envisaged at the start (Gregory 2003). To accommodate this, I explained to the participants the qualitative process and the lack of understanding of the experiences of practising as an ESP. By taking part, they were contributing to the understanding of the role. They could stop the interview at any time, ask for time to consider their reply or choose not to answer. All the participants signed consent forms and actively engaged in the interviews.

5.4 The Participants

The participants represent a wider group of clinical specialists than previous studies. They were qualified on average 23 years with 7 years in their extended roles. The types of extended tasks undertaken were consistent with those identified in the literature (Kerstein et al 2007; Stanhope et al 2012) but with some additional tasks. Three participants could refer patients on to a named consultant's theatre list, most could refer directly for a wide range of pathology and radiological investigations and three had supplementary prescribing rights having completed an approved course. This confirms the nature of a dynamic and changing role and the pace of change in the NHS in that new tasks and skills are being added.

The following table provides a summary of the participants outlining their speciality, qualification and type of tasks they were undertaking in their ESP role.

	Speciality	Years qualified	Years as an ESP	Highest Qualifications	Extended tasks	Title	Grade	Gender
A	Gynaecology	17	7	MSc	Named clinic Diagnostic tests	Clinical Specialist	8a	Female
B	Musculo-skeletal	30	13	MSc	Triage Injections. List for theatre Diagnostic tests Named clinic	Expert Specialist	8a	Female
C	Adult Neurology	21	12	MSc	Injecting Prescribing Referral rights Named clinic	Consultant	8a	Male
D	Pain	22	10	MSc	Prescribing Named clinic. Referring rights. Delegated consent	Clinical Specialist	8a	Male
E	Adult Neurology	22	8	MSc	Named clinic	Clinical Specialist	8b	Female
F	Paediatrics	20	9	MSc	Named clinic Injection Diagnostics	Clinical Specialist	8a	Male
G	Adult Neurology	35	15	Master's Modules	Named clinic Referral rights	Clinical Specialist	8a	Male
H	Gynaecology	27	16	MSc	Named clinic Diagnostics Referral rights	Clinical Specialist	8a	Female
I	Musculo-skeletal	25	7	MSc	Named clinic Diagnostics Listing	Clinical Specialist	8a	Male
J	Paediatrics	18	7	MSc	Named clinic Diagnostics Referral rights	Clinical Specialist	8a	Female
K	Respiratory	19	9	MSc	Prescribing Diagnostics Named clinic	Clinical Specialist	8a	Female
L	Cardiology	20	9	Master's Modules	Named clinic Diagnostics	Clinical Specialist	8a	Female

The participants grades refer to the Agenda for Change pay scales. This is a national scale for all NHS staff, except doctors, dentists and very senior managers, which assessed posts based on tasks, knowledge and freedom to make decisions as well as working conditions and responsibilities. It begins at grade 1 and progresses to grade 9 with the grade 8 pay scale sub-divide in to four separate scales rated a-d.

5.5 The Interviews

Tod (2006) described interviews as having the capacity to describe, explain, and explore issues from the participants' perspectives. However, Van Manen (1992 p67) warns that the interview needs to be disciplined by the fundamental question that prompted the research in such a manner that the researcher does not get carried away with the interview and "go everywhere and nowhere." To focus the interviews a semi-structured schedule was used (Appendix 6) beginning with an introduction, consent process and questions to capture the demographical details of the participants. This phase ended with the open question "how did you become the extended scope practitioner that you are today?" This question was followed by several prompts looking at the challenges and successes of the role, the relationships with other health professionals and the development of the role. It included an open question on their perceptions of the role they were performing and that of physiotherapy colleagues. This was to understand any perceptions or feelings the participants felt about the role that substantiated the tentative suggestions of Dawson and Gharzi (2004). A further open question asked what their role was like now in the changing NHS. The prompts focused on their experience in the role throughout their time working as an ESP. The interview closed by asking the participants where they saw their role in the future and with a question which invited them to say anything else about their experience that they wanted to add.

5.6. Pilot Study

The interview schedule was initially piloted on an ESP volunteer (not involved in the study). This volunteer provided frank and constructive feedback on their understanding of the questions and on how helpful the prompts or follow-up questions were. This practice interview was an opportunity to use the equipment and ask the questions. More importantly it provided an insight into how to manage silences and develop the skills needed to allow, or even encourage, the participant to manage the conversation rather than me asking questions. Underwood et al (2010) argue that to ensure the credibility of the interview the questions need to produce a collaborative approach to the research process and provide the participants with the maximum latitude to describe their perspective in their own terms. Verbal feedback from the pilot study provided the opportunity to construct prompts which enabled the conversation to flow but also to focus on the research question.

The interview schedule was a tool for the participants and researcher to work together in understanding the ESP experience. As Gubrium and Holstein (2012) suggest, interviews can be occasions when participants collaboratively, with the researcher, pieced together the accounts of their experiences. The interview situation, and my engagement with the participants, provided a narrative partner for them to explore and present their experiences. As Smith et al (2009 p56) explain, “participants should be granted an opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns at some length.”

5.7. Transcribing

The author transcribed the interviews and returned the transcripts to the participants for them to check for accuracy and maintain trust with the participants. It ensured that they were happy with what they had said, how they had said it and how it appeared in the text. This gave the participants the opportunity to make any further comments, delete comments or to request any additional information or clarity. There were no requests for further information or

amendments. Notes and a reflective diary were recorded post interview and during the research process (Appendix 9).

5.8. Reflection on the Interviews.

Reflection was a continuous process before, throughout and after the interviews. It became clear that participants' answers were in response to the questions asked during the interview and therefore great care needed to be taken to ask open questions orientated to the experience of being at ESP. The first interview when transcribed gave the opportunity to reflect on the amount of time each person talked. What became apparent was an eagerness to ask too many prompts and not allow the participant time to think and answer the question in their own way. This influenced subsequent interviews.

The number of questions was reduced and the prompts used became more open and empathetic "Can you expand on that?" "When you said that what did you mean?" Silences could go on without interruption as participants formulated their responses. On reflecting on the first interview, which was transcribed and reviewed before the second interview, there were occasions when I talked over the end of the participant's conversation. This influenced the flow of the discussion and maybe impacted on its direction. Riach (2009) refers to such incidents as "sticky moments" that suspend the conversational dialogue and may affect the structure and subsequent production of data. This insight was put into practice in subsequent interviews by actively listening and only interjecting to continue the conversation, seek further clarity or to ask another general question.

The interviews were transcribed into text and included the timed pauses and laughter but not every "ehm and ah" (example in appendix 7). In transcribing the interviews, it allowed the opportunity to identify possible themes which could be explored in subsequent interviews and to refine the interview technique. It became clear that patience and silences were tactful ways of prompting others to gain recollections. By asking for examples of experiences it brought participants back to the concrete experiences and prevented generalisations. The taped

interviews lasted on average 55 minutes, the longest being 70 minutes and the shortest 40 minutes.

By personally transcribing the tapes, and having the tapes available, it allowed for different layers of reflection. Reflection occurred during the interview as I actively listened to what was being said and explained. It continued when driving home and transcribing the interview. Reading and re-reading the transcripts, listening to the tapes to verify and recall subtle nuances added to the interaction with the participants' experiences. There cannot be a complete continuum of reflexivity because other things are important and take up conscious thoughts but having the tapes, having conducted the interviews and having transcribed the tapes into text, the transcripts became the participants' experiences. My perceptions from the interviews were that the participants believed they were providing an important clinical role which lacked recognition by the wider organisation they work in. There was also a sense of frustration and concern about their futures because of NHS finances. I, as the researcher, could empathise with their concerns but offered no advice.

What also became apparent in the first two interviews and changed the shape of later interviews, was the way in which the participants articulated how they thought and felt when undertaking the role compared to practising physiotherapy and the decision whether to wear uniform. This dichotomy of opinion was not articulated in the first interview but was raised by many of the participants in subsequent conversations. Although aware of such debates I was unprepared for the strong opinions and the differing perceptions of the participants. There were some participants who identified strongly with the physiotherapy uniform and clearly articulated that they saw themselves as physiotherapist with additional skills. In contrast, there were a group of participants who felt their role and practice was different to physiotherapy. They argued that wearing a physiotherapy uniform was not appropriate for the role. The uniform group had strong views that those not wearing a physiotherapy uniform were letting the profession down.

The interviews highlighted experiences in training, changes in practice, barriers to change, relationship with colleagues and other health professions. Surprisingly it also triggered responses on the frustrations and concerns for future developments, the notion of clinical identity and how the role is recognised by a wider health care community. These aspects were introduced as open questions in subsequent interviews and produced a significant depth of response from the participants. This is consistent with phenomenological interviews by allowing for flexibility in following up on points raised in responses to the given questions. Smith et al. (2009) recommended that the interview schedule should be used flexibly to allow for unanticipated information to emerge. Using a format that is too structured could lead to participants being less forthcoming in their responses (Pringle et al. 2011) and a lost opportunity to gain understanding.

At the end of each interview a written reflective diary was completed which identified the successes during the interview and areas that needed reviewing. The reflective diary was used as a method of framing conscious reflection and encouraged learning from the experience (Blair and Deacon 2015). It also recorded impressions given during the interview by the participants and any comments made when the tape was turned off. The first interview was conducted in mid-January 2012 and the final interview was completed at the end of April 2012.

5.9. The Effects of Power.

Marshall and Rossman (2006) argue that research fundamentally involves issues of power; there is an unequal relationship between the researcher and the participants. Participants might feel compelled to take part especially if they perceived the researcher to be in a powerful position (Finlay 2006). The research proposal acknowledged the potential power relationship in that I was a head of physiotherapy, and although they were senior experienced staff, they might apply for senior posts in my hospital. As such they may have felt compromised about speaking openly during the research for fear of effecting future career opportunities.

Two things minimised the influence of power between the participants and the researcher. The first was the change imposed by the REC in that the participants had to contact the researcher. The participants were in charge, at all points, they had the final say in whether to take part or withdraw from the study or amend or delete the transcripts. Secondly, at the time of the interviews, the researcher was no longer a physiotherapy manager. Due to organisational change and redundancy I was no longer working in the NHS. I became a physiotherapist interested in their experiences of being an ESP. This was explained to the participants before the interviews.

Van Manen (1992 p163) in discussing ethical effects identified a positive transformative affect that phenomenological research can have on both the participants and the researcher. By heightening perceptiveness and thoughtfulness through the interview new way of looking at things can become apparent. Listening to the tapes it was noticeable that the participants relished the opportunity to discuss the creation and development of their role and reflect on the successes and challenges they had encountered. This desire to describe the experiences of the role ensured that the participants were willing colleagues sharing their past and present endeavours and concerns for the future.

5.10. The Analysis of Transcripts and Reflexivity

Within phenomenology, analysis has traditionally not had a set of procedures or techniques. There is a philosophical aversion to providing rules which may prematurely foreclose possible ways of understanding (Langdridge 2007, Smith et al 2009). The emphasis is on creative engagement with the text “to transform lived experience into a textual expression of its essence” through artistic endeavour (Van Manen 1992 p36). In practice, the task was to produce a coherent text which captures the structures and meaning of the experience of the ESPs.

In the research process, there is phenomenological reflection that aims to clarify and make explicit the structure of meaning within the lived experience. This meaning is multi-dimensional

and multi-layered which can only be communicated textually by well organised narrative prose (Van Manen 1992). The narrative had to emphasis, within the prose, the “meaning units” or themes to provided clarity of the nature of the lived experience to the reader. These themes had to have certain qualities within the experience that could put into words something to be reflected upon (Gill 2014). This was the aim of the analysis.

The taped interviews were transcribed and formatted with large margins and numbered lines so that notes could be made alongside the text (Appendix 7). The line numbers facilitated referencing parts of documents. Each transcript was read in its entirety with no notes being taken to gain an overview of the conversation. On at least two occasions the taped conversation and the text of each interview were read and listened to together. Any additional nuances from the tape, such as laughter or strength of feeling in the voice, were referenced within the written text. This was then cross referenced to post interview reflective notes. On subsequent readings notes were made in the margins as themes, statements or ideas emerged.

The format followed the suggestions of van Manen (1992). Focussing on one participant’s data at a time, analysis moved from the descriptive to the interpretative by capturing initial thoughts, generating tentative themes, and then refining these themes through writing. This required multiple sessions of revision and crafting. The aim was to create a balance between the parts and whole of the texts orientated towards the participants` experiences.

In practice, themes were transferred to sticky notes and grouped into clusters based on similitude supported by statements of the participants. These ideas were reviewed across the whole cohort of participants and the first draft of themes, was committed to paper. The analysis of the texts followed the spirit of Van Manen`s notion of an “inventive thoughtful attitude” (p47) in which the data was written down, critically looked at, re formatted and looked at again until the themes and the sub themes could describe the experience as disclosed by the participants.

This was a time consuming and challenging task. After several months of distilling the texts into possible themes there appeared to be a degree of incongruence between the segments and the whole. The analysis seemed to focus on a process; how the roles came into existence and how they developed. While this was an important experience of the participants what seemed to be missing were the personalities, the enthusiasm and the drive of the individuals. My thoughts had a linear, almost self-imposed rational framework which seemed to simplify the conversation and miss the connective experiences.

What also became clear during this process was that the language used to describe an experience plays important parts in the construction of the meaning to that experience. Language has a constructive dimension and categories and labels used during the research process shape findings (Willig 2006). Assigning labels too early to a theme influenced the interaction with the text and the search for alternative understanding. My initial analysis seemed to miss the sum of all the parts in understanding the participants' experiences. There was a realisation, which was forewarned in previous background reading, that the analysis of qualitative data requires powerful inductive skills and creativity to discern patterns and to weave them together into a unified whole in an insightful way (Polit and Beck 2010). Or as Smith et al (2009 p40) describe it, "successful analyses require the systemic application of ideas, and methodical rigour; but they also require imagination, playfulness, and a combination of reflective, critical and conceptual thinking"

A second critical issue became the time needed to analyse the data. There was a need to create uninterrupted periods of time when I could become completely focused on the research oblivious to the routines and pressures of daily life. The actual length of time varied but more important was the quality of time and capturing the moment when thoughts became clearer or new ideas developed. The nature of part time and independent study also became a factor during the analysis. Productivity and motivation varied and constraints of time impacted on the quality of the insight. Like Dean et al (2006), in part time doctoral study, there were periods when momentum and enthusiasm waned. Perhaps, more critically, the analysis needed a

more creative and visual impact so that data and ideas could be picked up at different times in the process and the memory refreshed. It was this creative visual overview of the whole which was needed to make sense of the detail. Post it notes on work tops did not seem to work and so at this point several months into the analysis I took a break.

The analysis of the data therefore occurs in two different time frames. The first stage began in February 2012 and ended in August 2012. From September 2012 until September 2013 there was a break in the study as I decided to retrain as a teacher and not return to the NHS. This break allowed me time to carefully consider whether to continue with the research. In reflecting on this decision, I concluded that I was still interested in the subject and believed that it provided an important insight into changing roles. So, in October 2013 I started again with a fresh mind and renewed vigour.

With the need for a more creative relationship with the written word I went back to all the transcripts and with blank sheets of paper in landscape form reread them and created a mind map of each of the participants' experiences (Appendix 7). This was completed over two consecutive days and allowed total immersion in the data and the experiences of the participants. This was a departure from what was originally envisaged but is consistent with the philosophical argument of the methodology advocating a non-prescribed structure in analysing the data and the notion of insightful inventiveness. It provided comparison between the spoken word, the text and a more pictorial representation of each. In doing so it allowed the texts to be compared.

Buzan (1995), who is credited by some as creating the process, has formalized the concept of mind mapping by creating a series of guidelines including the use of colours, the thickness of lines but he also concedes that part of the process is to let your own map develop through interaction with the subject. By analysing the text in a drawing form, it allows new links to be established between themes which include rather than exclude the irrational and non-linear. Eppler (2006) argues that mind map can be a tool to support cognitive processes such as thinking, idea generation representation, vocabulary explanation and visualization. Or as

Peneder (2008) found, a mix of creativity and organisation can help to clarify thoughts. He et al (2015) found that mind maps also provide a link between different levels of a topic. In using the concept, it provided a link and relationships between different sub themes and themes.

Examples of the mind maps are included in the appendix 8. Each is different in terms of the amount of writing, the interconnections and the colours used. This represents the individuality of the participants, their conversation and text. The process of producing the mind maps and the outcome provided a fresh reflection on the experiences of the participants and the commonality they all had in undertaking these roles. It gave a fresh impetus for writing a narrative. This process stayed true to the Van Manen (1992) argument that by committing one's thinking to paper it stares back and provides the opportunity to reflect. Comparing the narratives to the mind maps allowed further refinements of the themes and provided greater clarity. Both seemed to complement each other. There were recurrent themes within the experience for all the participants. The intensity, or strength, of the themes varied between participants but they could be identified both in the narrative and mind maps. The nature of these themes was committed to paper and discussed at length in supervision.

These have been remodelled and refined through reflection and critically reviewed in supervision during an eighteen-month period until they could be woven together, using the participants' voices, to articulate their experiences. The themes occurred throughout all the participants' descriptions and more importantly throughout their careers as ESPs. Each theme had a different impact on experience at certain points during the participants' career journeys and these themes were still relevant as they discussed their current roles in a changing NHS. In following the methodology, it was only after the themes were committed to paper that an understanding was sought. This led in the direction of institutional work.

The combination of rich data and literature on institutional work are used to provide an interpretation and understanding of the participants' experiences and an insight into the mechanisms and implications of their changing roles. The following chapter considers each theme and its parts in turn.

Chapter Six: Description and Interpretation of Themes

6.1 Introduction

Over the many drafts each theme has had different headings. The first theme was initially titled “individual traits and self-worth”. The participants described their experiences and ability to deal with set-backs, the need for recognition, self-belief and motivation. Over the course of 18 months the theme heading changed to the term agency, influenced by applying the concept of institutional work. In doing so it gave a label to the individual characteristics of the participants which include; motivation, opportunity. identity and their choices of action or inaction.

The second theme was initially “power and influence”. What became apparent very quickly was the power of the medical consultants to influence the participants` careers and sphere of work. In some cases, certain opportunities were actively blocked by the consultants to the frustration of the participants. While for others, the medical consultants actively facilitated and supported the role development. The participants clearly identified in interview the factors which triggered support for their role. However, for those who experienced resistance they developed tactics to challenge this power. In doing so, they were activity engaged in negotiating professional boundaries. Sometimes they were successful and sometimes not. Although consultants were a significant group the participants also negotiated with others, medical managers and other professional groups such as nurses. Negotiating boundaries was the key theme.

The final theme began as change and adaption but what became clear was that this was a process in response to NHS changes. All the participants identified the changes affecting them, the services around them and the ways they adapted or were adapting. For many it

provided the opportunity to reflect on their clinical journey and consider their clinical and professional futures.

The three major themes and eight sub-themes are highlighted bellow:

Agency (with sub-themes: Motivation, Opportunity and Identity)

Negotiating Boundaries (with sub-themes: Hospital Consultants, Medical Managers and non-medical healthcare professionals)

NHS Change (with sub-themes: Change and Adaption)

The next three sections take each theme and sub-themes in turn examining each from the experiences of the participants

6.2 Agency

6.2.1 Introduction

Giddens (1979) described agency as a continual flow of conduct by which actors intervene in a potentially malleable world. Actors have a choice and a degree of insight into their actions. Ballinana and D'Aunno (2010) extended this and described agency in terms of motivation, intentionality, choice, autonomy and the ability to operate somewhat independently of the determining constraints of social structures. It accommodates the argument that actors (be that organised groups or individuals) are not only shaped by existing institutions but by engaging in institutional work they may shape those situations and produce change.

The three aspects of this theme centre on the motivation and actions of the individuals and the opportunities they saw or developed to create and maintain the role. It uncovers the impact of these actions on some of the participants, in terms of professional identity and relates this to their perception of where they place themselves relative to the physiotherapy profession. This is a surprising and important discovery as it provides some understanding of a tension that occur as institutions, in this case physiotherapy, begins to evolve through the influence and agency of individuals. For many, they were clear that they were physiotherapists with additional skills and were comfortable with that identity. For a smaller group, they described thinking and acting differently in clinical practice. They felt they were different to physiotherapy colleagues.

6.2.2 Motivation

In all the interviews, the participants were keen to stress that the roles were created and shaped by their own personal drive and ambition. From the origins of the role and throughout its development (including recent changes) the participants pushed for change as described by Participant I.

“I think I saw there was a need for developing (a service) to deal with patients with knee problems, knee problems better than we were dealing with them.”

Participant I believed he could provide a better service than had previously existed and actively lobbied for the role.

“I felt there was a need to put something into there and that was one of the driving forces”

This personal drive to do something and create a role was echoed by Participant F in describing his development of using injections in clinical practice.

“I heard there was this injection course for physiotherapists and I spoke to my consultant who said that's a good idea. If you can help out with injections, then you will be helping the throughput of the clinics”.

Participant K in discussing the clinical areas she had developed described how she pushed for change.

“So, the area that I have developed since coming into post is that I do blood gases. I set up the non-invasive ventilation on all the patients. I have done a prescribing course so it is things like that that have evolved over time really.”

When asked about the supplementary prescribing course Participant K described how she pushed herself forward.

“I had read about it in Frontline (a physiotherapy journal) when it was first coming out. Then when the course became available I approached xxxx (deleted for anonymity) and she said

that great, go for it and so I did. And I was lucky that it was at a time when you were released to go and do those things one day per week. So yes, it was a good course.”

From the participants, there was very much a focus on “I did this” or “I had to push for this”. They were self-motivated with a sense of what they wanted to achieve as described by Participant C.

“I suppose to start with there were quite a few hoops to jump through”

This concept of hoops was also brought up by Participant J in creating her role.

“So, I had to find the hoops to jump through, find them and then jump through them. It was an interesting process”

Both participants had the personal drive not to let these “hoops” get in the way.

Lawrence et al (2010 p6) argue that the concept of institutional work is based on a growing awareness of institutions as a product of “human action and reaction motivated by idiosyncratic personal interests and agendas for institutional change or preservation.” The participants discussed their reasons for creating change which centred on their vision of doing things better, enjoyment of the challenge in a clinical area they were passionate about and a sense of achievement and satisfaction in achieving change. Participant A identified that working with patients in a speciality she enjoyed was a motivating factor in developing her extended role.

“I think that for someone like me who had a particular area of interest they wanted to develop and wanted to work in, then, I think it is an ideal opportunity.”

Participant G identified that his significant involvement in the creation of a clinical pathway was.

“My personal achievement and something I'm proud of.”

Two other participants identified the desire to learn and the challenge of the role. They gave personal satisfaction as one reason to extend their clinical role.

“The drive for the development has been pretty much being led by my interest and my desire to learn and to develop.” (Participant D)

“I’m very happy in my work. We all have bad days but generally speaking I still find it very rewarding and challenging.” (Participant F)

This desire to acquire greater learning, in an area of clinical interest, was identified by Currie et al (2009) as a significant decision factor for GPs to take on special interest roles. This enthusiasm is clearly identified and evident in the way the participants described their roles and confirms the opinions of Kerstein et al (2007) and Stanhope et al (2012) that this enthusiasm is a driving force for change. However, the participants were also very aware of the need to demonstrate an efficient, effective and safe patient service. They were at pains to demonstrate and document the outcomes of their interventions and open themselves to the scrutiny of others.

Participant J describes how she was determined to demonstrate the effectiveness of her clinical practice and role.

“So, I set up this quite big audit and then I feed those results back to the consultants and it was a really useful piece of work but nobody would have asked me to do that work in a million years. It was very much me saying I done this work.”

The response from her medical colleagues was a little underwhelming. They described her audit as.

“A really, really good piece of work. Doctors would never do this but it’s a really good piece of work, if not a little anal.”

The tone of J’s voice in discussing this incident underlined her exasperation and frustration but she also recognised that it was her driving the developments forward. The medical

consultants did not ask for the audit but she felt the need to show them what she was doing and how effective her interventions were in terms of patient outcomes. She wanted to demonstrate, and be recognised, that her role provided an efficient and effective patient service.

For all the participants, there was a very personal commitment and identification with the service they provided through their extended role. Participant I described auditing his service to prove its clinical effectiveness and provided evidence to support his role.

“We decided that we would do this initially, to audit initially, to, (pause 4 sec) effectively prove our worth I suppose. There's always the possibility that you will get people within the system, and I certainly come across a few who are obviously not that supportive, don't really see that there is a requirement for the service. So, I think from that point of view it's good but also to look at whether there is any way of improving the service, anyway of fine tuning that. To actually use those figures to prove what we do and therefore say this is what we are doing this is what we can do for you, we would like to expand the service.”

There were several reasons for this self-imposed need to prove their effectiveness probably best summarised by Participant B.

“You have to be able to put your money where your mouth is. Really you have to show that you are competent and that you know you have progressed.”

In creating the role, the participants realised the need to have evidence, in terms of audits, to support their clinical effectiveness, patient safety and their clinical competency. They did this, even if it was not requested or considered by other professional groups, for personal satisfaction but also just in case they needed later it later to justify the role as Participant I explained.

“The biggest change has now come in that, not only has it got to work but you've got to be able to provide appropriate evidence that it will work. I just can't say this is a good idea why don't you just try this. I've got to demonstrate it on the patients, that's what I've always done but I have to be able to evidence it as well.”

The participants were aware that in creating these new roles their profile and the profile of physiotherapy was raised. This put them under some pressure.

“I think that most people that go into senior clinical roles and are pioneering the extended role approach are extremely well motivated, have high professional standards and are very aware that they are not just shouldering their own professional development but also the professions. That if you make a cock up it probably sets the development of something like that, in the same area, back five or ten years.” (Participant D).

The participants realised that they had to produce evidence to support the role and present this as a reason for change. As Marti and Mair (2010) argue, less powerful actors are more likely to bring about change which was incremental, careful and sensitive to the wider domain. This was compounded by the lack of a professional pathway of development within physiotherapy as Participant D explained.

“There is no obvious CSP structured career pathway for the development of my role. There is no set of competencies as such.”

Therefore, like many of the participants he had to create his own framework or seize opportunities as they arose. The participants were sensitive to the dynamics of the clinical area and current political changes within the hospital and the wider NHS. Participant A described how the current situation had presented more opportunities at the expense of opportunities for nursing colleagues.

“I perceive that the pendulum has swung since I started, and that has nothing to do with me, but when I first started I think the nurses in the service were much more high profile then we were and I think that has changed. I think because in our team, we are all very much enthusiastic and well-motivated and we genuinely want to do the best for everybody and we're all like that.”

While the motivation and actions of the participants were crucial parts of their experiences they also needed the ability and freedom to act. The opportunities were on occasions fortuitous

but even so the participants still had to be in a position or mind-set to take them. This is discussed in the following section.

6.2.3. Opportunity

Participant C explained how his role started.

“Why me, I suppose I was the person approached by the consultant who said ‘are you interested in extending your scope of practice’ I was at a point in my career where I thought it was the direction to travel, rather than going down a management angle, to go down the clinical specialist extended scope angle and so the timing was quite good. I suppose nationally there was a push for non-medical staff to pick up the traditional medical roles to deliver more for less money I suppose.”

Participant C was thinking of making this move for some time and describes why he grasped the opportunity.

“If the consultant hadn’t approached me, I suppose, I would have sought out the role elsewhere. I think I was quite keen on it. I could see it was the direction for the specialism and people were beginning to talk about developing the specialism at other sites nationally. So, I suppose that was a driver of sorts when she said we could be the first site to get someone doing this practice.”

The other participants actively approached the consultants. They identified a gap in the service they could fill which would reduce the workload in clinics for consultants and allow more patients to be seen as several of the participants explained.

“There was a gap in service which I have the necessary skills to fill that gap from an assessment and treatment perspective and I had an interest anyway so I stepped in.”
(Participant F)

“The Orthopaedic consultants that I worked closely with were quite happy for me to develop a service and the accident and the emergency consultant who I knew quite well at that time. He

was quite happy for me to develop a role as well to actually work with acute knee injuries.”

(Participant I)

“The orthopaedic surgeons basically said, ‘Ehm a physio could do this, couldn’t they? You could do this?’ I just happen to be in the right place at the right time and I sort of said yes but that is outside of what we normally do. These patients are normally coming to see you not us and so it just sort of developed from there really and it was on the back of them needing to meet their waiting lists targets.” (Participant J)

Reducing the workload for consultants and helping reduce waiting lists was a recurrent theme in providing an opportunity for change and reducing barriers. Participant C emphasised the pragmatic nature of sharing work while also identifying how being known to the consultants facilitated practice.

“I think with the type of organisation it is, I think all the clinicians tend to be fairly pragmatic. So, if you pick up a clinic from say, one of the neurologists, that eases his workload. To be honest they tend to be very grateful, they are happy to give the work to you…… I’ve always taken work off overworked people so my work doesn’t impinge on anyone’s role without their consent or without discussion before-hand. I’ve been approached to do this work.”

Participant H highlighted how the adoption of recent technology changed how patients were referred to consultants and stimulated a change in one consultant’s behaviour. Originally Participant H had all her referrals and discharge letters screened by one consultant. The consultant would decide which patients the participants saw and would check discharge letters. There was a high degree of supervision which frustrated Participant H because she felt competent to assess the patients independently and arrange appropriate treatment and discharge. She explained her frustration caused by this supervision.

“I think the frustration was initially medics not really seeing the benefits of this kind of service and not wanting to lose control of what was happening. For example, we dictated letters at the end of the clinic to go out to GPs, as the doctors would do, but we never officially allowed to

sign the letters. The consultant had to check the letters and sign them. And the frustration was, that we knew, they would wait for weeks to be signed.”

Despite two years of argument, as to the practicalities and efficiency of this practice, the senior consultant would not change her mind and insisted on her protocol. Interestingly all this changed with the introduction of electronic referrals and letters.

“We don’t even sign the letters now because of digital dictation and it’s all done electronically. We go on the screen and click, edit and approve.”

This change in practice prompted the consultant to stop reviewing Participant H’s letters because...

“She didn’t do technology at all, bizarrely.”

This left an opening for two newer and younger consultants to work with the ESP.

“They are much keener on developing things such as pathways and looking at the service and how it develops and grows and to work with the ESPs to push the service in a new direction.”

Greenwood et al (2002) suggest that changes in regulation, technology or competition stimulate transformation and provide an opportunity for actors to engage. The introduction of electronic referrals provided the stimulus and opportunity for Participant H. In addition, the financial pressures within the hospitals created further impetus for change.

Hospital managers tasked with meeting increased clinical demand within a finite budget began to take an interest in the practitioners and the roles they were undertaking. This recognition provided the opportunity for the participants to discuss options with hospital managers. These types of negotiation are discussed in the next theme but for now the focus is on “recognition” providing an opportunity. For the managers, the role had become an entity or a job a non-medical practitioner could do. Berger and Luckman (1966), in describing the social construct of reality, argued that if action is repeated frequently it becomes a pattern that can be performed in the future with a degree of economic effort. When this action becomes associated

with a type of actor a process of institutionalisations occurs in which the action and actor become linked. Over time they create a history which becomes an objective reality recognised by others, the role becomes a reality. The role of the ESP was recognised by managers as a part alternative to a consultant and could help meet clinical demand.

Participant J described ongoing conversations between different clinical managers about replicating her role.

“I know there have been discussions between the managers from paediatrics and the managers from Orthopaedics about this person XXXX (removed for anonymity) who does this clinic, as in it works very well for Orthopaedics, why don't you have one? So, the discussions have not been about me as an individual, just about the role.”

Lawrence and Suddaby (2006) argue that one of the processes of creating an institution is the need to construct an identity which describes the relationship between an actor and the field in which the actor operates. The role created and associated with Participant J had moved on to be a role independent of the individual. What cannot be established is whether the role was uniquely associated by the managers with the physiotherapy profession or seen as additional skills that could be learnt and practised by any other non-medical healthcare professionals to meet demand.

Undertaking non-traditional roles in a different environment away from main stream physiotherapy produced, in some of the participants, a questioning of professional identity. Richardson (2000) argues that, from the first day of entering professional education through to retirement, a physiotherapy practice culture is being developed through social interaction that takes place in physiotherapy departments. However, for the participants this was not the case. They practised, for most of their clinical time, in a medically orientated environment taking on roles previously done by medical colleagues. The impact was that most identified themselves as physiotherapists with additional skills but for a small group, the role, their thinking and the way they perceived themselves had altered.

6.2.4. Identity

In terms of thinking differently Participant B went into some detail about using a medical framework or model to examine patients rather than a physiotherapy assessment.

“You have learnt to think about the medical model of questioning as opposed to the physiotherapeutic (sic). It's a much more compact way of questioning the patient..... you tend to become more medically orientated because you're working with medics. You take up their jargon, if you like, because that's what they're used to. So, if I'm looking at X-rays now it's much more medically pinpoint then, what say, a physiotherapist would have done because they've never had that sort of training in that discipline.”

When asked why she took such an approach Participant B explained.

“When a GP refers a patient into your clinic they are not referring them in for physiotherapy. They are referring them in for an opinion which means, at that point, the care of the patient is taken over by you.”

Participant C discussed the broader range of decisions he had to make as an ESP rather than as a physiotherapist.

“The decisions that you take as an ESP take into account, I think, a much broader possibility of interventions for your patients. I think that there is a risk with specific professions that you develop a sort of armoury, you develop a set of skills or techniques to deal with particular conditions and that sort of limits your professional practice. But when you look at extended scope and you look at what the broadest possible types of interventions for patients, whether that be things like psychology, surgery, pharmacology then that becomes more to the forefront of your decision making.”

When asked if he still felt that he was a physiotherapist he replied.

“I feel differentit's a matter of degrees really. In my extended scope role, you have about 75% ESP and 25% physiotherapy going on in your head in terms of decision. Working as a

physiotherapist most my thought processes will be around physiotherapy intervention and the specifics about which sort of interventions will work well and then a small bit in my background of my mind thinking actually, maybe this person might benefit from surgery or an injection or some alteration to the medication. So, I suppose the emphasis changes depending on the setting that I am working in."

The additional knowledge and options of intervention altered the participant's perception of the patient's condition and the actions he might initiate. Participant D also thought differently when working in his practitioner role as he explained.

"I think you just have a different mind-set and a different view on things in comparison to being based on a traditional outpatient (physiotherapy) department.....I think of myself as a physiotherapist and I'm proud to be a physiotherapist and I wouldn't want to be anything else but I don't think my role is easily comparable with a regular physiotherapist role I think it's much more akin to a medical. I think that patients tend to assume that it's the medical role and even when you introduce and explain who you are and what you're doing I don't really think they get it. But at the same time, I don't feel I..... I think I see myself as physiotherapist but if you ask my colleagues in physiotherapy they probably say that they don't see me as physiotherapist. That's probably a fairer way of saying it."

Participant I seemed to reinforce this view.

"There is a lot of what I do within clinics that utilises my physiotherapy skills. I think I am very good at examining joints.....I utilise my physiotherapy skills, so there is a lot that I use there. I think perhaps where I differ is the overall management of patients and advice on how they should be managed. I'm using my knowledge and skills that are required, no acquired, from working with a rheumatologist but also in working with the orthopaedic system. So, I know what the rheumatologist is thinking about, management. I know what the surgeons are thinking about, management.... Now is that a physiotherapy role or skill. It is a clinical role and skill, very definitely and I think it's one that physiotherapists can acquire and should utilise if they

acquire knowledge and skill. So, there is not a straightforward yes or no answer to that question."

Perhaps with some candour Participant I summed up the identity dilemma.

"I'm not, I know it sounds awful doesn't it, a run of the mill physiotherapist. I'm not a normal physiotherapist, I'm a clinical specialist and consider myself towards the top of the tree really and yes I want to convey that to an extent."

The disclosure that some of the participants felt different to physiotherapists is an important admission. Schon (1983) argues that professional practice relies on the ability to think in action and derives from a tacit knowing which spontaneously articulates actions, recognitions and judgements. Training and knowledge become internalised and part of practice. In these four participants, the medical perspective became part of how they view their professional role. This manifested itself in the way they use more medical language (or jargon), how they examine patients and their decision not to wear a physiotherapy uniform. These participants argued that they thought differently to other physiotherapy colleagues and therefore had some problems identifying with being a physiotherapist.

Timmons and East (2011) contend that uniforms are one of the key ways in which occupational boundaries are enacted in practice by providing clear visible symbols of a profession. This small group choose not to wear a uniform so as to appear distinct from their physiotherapy colleagues supporting Bazin and Aubert-Tarby (2013) conclusion that the adoption of a way of dress is never innocent and can be used to show one's view

Participant C explained why he did not wear a uniform in his clinic.

"I suppose, I see it as being slightly distinctive. The thing for me is, in some ways it makes the job a bit easier. I think the physiotherapy uniform is distinctive and I think a lot of patients recognise it and I think that creates a degree of confusion with the patient in the clinic room and that requires a degree of explanation which in the clinic setting you don't have lots of time to do really. It's a lot easier, I find from experience, to introduce yourself as "I'm the

physiotherapist working in the clinic to do your treatment today” and then that's it done with. You take the initiative, where as if the patient walks through the door and there is a visual difference they are the ones that initiate “oh I thought I was going to see the doctor.”

Participant I was even more explicit in why he didn't want to wear a uniform even though it put him in conflict with his physiotherapy manager.

“This is an ongoing battle I'm having with my line manager at the moment (laughter). It is a patient perspective thing. The reason I don't wear a physio uniform is a patient perceptive thing. And it was a conversation I had with a chap who used to work here within the same role as myself and he said that he used to wear a physiotherapy uniform when he was working, he was working as a spinal ESP, and he started off wearing a physiotherapy uniform and he quite often had patients come in and say, “am I not seeing a doctor today, I thought I was seen doctor,” even though he introduced himself as a physiotherapist before and after. And he felt that the patients` perception of the care they were getting with different with him in uniform. He started to wear a shirt and tie and he said that very definitely there was a different perception. There was a definite change in patients` perceptions if you wore a shirt and tie even though he still introduced himself as” hello I am so and so I'm a physiotherapist.”

They reasoned that this was for the benefit of the patients and was more appropriate in medically orientated clinics. The consultants did not wear a uniform so they did not wear one. Timmons and East (2011) reported similar feelings when they interviewed clinical nurse specialists (CNSs) who, due to a change in hospital policy, had to change from non-uniform to a corporate uniform. The CNSs were upset by the fact that doctors did not wear a uniform but they now had to and related this to their own perceived loss of status. They argued that in their own clothes they were treated differently from other nurses and this non-uniform allowed others to understand who they were and what they did. Bazin and Aubert-Tarby (2013) identified that dress code is part of an organisation identity but also conveys an individual's identity and can project a sense of self. The way that someone dresses can change the way they consider themselves.

Participant I did acknowledge that by taking this decision it did give the impression of being a doctor and that this had been commented on by physiotherapy colleagues.

*“One of my friends who works within physiotherapy always calls me Dr ***** (removed) and, you know, he reckons I'm just trying to be a wannabe doctor. My boss at the moment is trying to get me back into a physiotherapy uniform and what I've said is that, that am happy to do that, on the days that I don't do clinics but when I do the various clinics that I do I will continue to not wear, a physiotherapy uniform.”*

They identified themselves as physiotherapist in consultations with patients (as they were legally obliged to do so) but felt that their role was different.

“It's not about trying to con people and pretend you're something you're not, it is made very clear to everybody that I come into contact with, who I am or what I am and what I do.”
(Participant D)

They did not see themselves as doctors but felt they were different and wanted to appear distinct from a physiotherapist as Participant B explained.

“The reason for that is that you don't want to appear in something like a physiotherapy uniform or nurses` uniform because people associate you as purely a physiotherapist. We did that initially and it fell quite badly because people said I'm not listening to you because you're just a physio. So, it was decided that we would do that and so the decision was made that we would be in civvies and I think that is the right decision.”

Goffman's (1959) describes different ways in which self can be presented to an audience. At one extreme, a performer can believe that what he is doing is reality and this reality is shared by the audience. Conversely, the performer may not believe in the routine but still guide the conviction of an audience to an end. There may be no malice or gain in this delusion because it is aimed at a common good. Goffman (1959) describes this performance as a front which is in part dependent on the setting and appearance of the individual. In some ways, the latter

describes these four participants. They are attempting to convey a front which inspires confidence in the patient and recognition of their role.

Bevort and Suddaby (2015) found in interviewing individuals involved in changing roles in a large Danish accountancy corporation that the critical mode of engagement with the new logic (or new ways of practice and roles) was predicated on an existential level in which the actors struggled with the question 'who am I' and 'what is my personal role to be in this new mode of organizing?' They found distinct differences in actors' abilities to successfully integrate the new logic into their individual professional identity. They argue that the successful integration of the new logic was an important element in the process of organizational change. These four participants illustrate the experiences of this change and expose an intermediate step of not knowing or being unsure of what they were professionally. It also confirms Giddens (1979) assertion that creating an identity is both a liberating and troubling experience which can produce anxiety over the choices made and the outcome of those choices.

For the larger group of participants, they were clear that they were physiotherapists. This manifested itself in how they described their experiences and the affinity to wearing a physiotherapy uniform. Participant J articulated why she believed that ESP should wear a uniform.

"I sort of feel we are just reinforcing the idea that you have to look like a doctor, otherwise your opinion is not relevant. I want patients to respect me on the basis that they know that I am a physiotherapist and I treating them well enough to take me at face value rather than, kind of con them a bit and for them go out thinking that they saw a doctor. I think that that just becomes a self-fulfilling prophecy, that we never convince people that therapists can do these jobs. That's why I wear a clinical uniform."

Participant A was emphatic about wearing a uniform.

"I still want to be seen as a physiotherapist, definitely."

For this group being recognised as a physiotherapist was important and the wearing a uniform symbolised the profession as Participant L explained.

“I like the patients to be able to identify with the uniform and I like to wear a uniform because I think it distinguishes you.”

Participant G went further when describing the importance, he felt in wearing a physiotherapy uniform.

“I have to say, because of the way I was trained, because of the way I was brought up as a physiotherapist, because of this strong belief that uniform is part of identity, as part of my whole development as a physiotherapist..... it's not only part of my identity as physiotherapist it's part of my professional behaviour.”

Adler and Kwon (2013) described the institution of professionalism as both a type of occupation (the profession) and a type of individual work activity (the professional) which can be in a state of tension particularly at times of sustained change. Social familiarity facilitates trust and communication as actors speak the same language and share the same knowledge and assumptions. The small group of non-uniform wearing participants emphasised the close working relationships with medical consultants and the way they approached patients. Their distance from other physiotherapy colleagues and closeness to medical practitioners created, in some, this confusion

Marti and Mair (2010) argue that any study of agency cannot be detached from an analysis of either the intended and unintended consequences. The next theme identified how the participants negotiated their new boundaries, their successes and failures and the consequences of the changes.

6.3. Negotiating Boundaries

6.3.1. Introduction

The second theme captures the participants' experiences of negotiating new boundaries of practice through active and purposeful actions with hospital consultants, managers and non-medical colleagues working in the same clinical area. For clarity, all medical doctors, in whatever speciality, are referred to as consultants. Extensive research has shown how the prevailing institutional arrangements in health care have strongly favoured the autonomy and power of the medical specialist over other groups (Friedson 1970, Battilana 2011, Curie et al 2009, 2012). Medicine is at the apex of the healthcare professional hierarchy and retains a significant and powerful position (Currie et al 2012). What is not examined in detail in this study is the notion of consultant or medical power in the NHS.

Bourgeaut and Grignon (2013), in a comparison of health professional boundaries across Canada, the UK, the US and Australia, concluded that getting closure and dominating other professions is based on social prestige and connections and this explains why medical doctors have this control. However, they identified that across all four countries, to varying degrees, this dominance was being challenged mainly due to increased demand and economic pressures from central governments to reduce health care costs. This, they argue, meant that medical doctors must consider how services are delivered and re-adjust their position within health care to maintain their hierarchical dominance. There is some evidence to support this re-positioning from the experiences of the participants but it must be acknowledged that consultants still retain a significant and powerful position in health care (Batillana 2011). This study highlighted the experiences of ESPs negotiating with this powerful profession and illustrated successful and unsuccessful changes. More importantly it uncovered some of the reasons for or against change and the reactions and tactics used by the ESPs in attempting to create and maintain their role.

The participants also identified the increased importance of general managers (and commissioners of health care) in creating and sustaining their clinical role. This was a more recent feature for all the participants and came to prominence over the previous three years (2009-2012). Giaimo (2002) suggests that hospital managers act as diplomats to ensure that the work of doctors is facilitated. Yet the participants found managers more concerned with facilitating clinical productivity and cost reductions. For some, this made the hospital manager more receptive to alternative ways of working. The participants explained how they used this new emphasis to strengthen and maintain their clinical position despite competing demands for resources.

The final sub-theme, in this section, examines how the participants negotiated their position and boundaries with other health care professionals in the same clinical area. It highlights the active decision making and the occupational behaviours employed to maintain their clinical position in relation to other professional groups. The experiences of the participants identified that several professional groups may be engaged in changing occupational boundaries at the same time. Abbot (1988) focused on the importance of acquisition and control of tasks in the workforce and the jurisdictional disputes that occur over professional boundaries. In contrast, the participants in this study articulated their motives and intentions for change and the more collaborative agreements that enabled roles to develop. This contrasts with the negotiations and actions that occurred in the professional relationship with consultants.

6.3.2. Negotiating with Consultants

All the participants identified the crucial part medical consultants had on their experiences. The main feature of this support appeared to be a personal engagement (or professional relationship) that had developed between the practitioner and consultant and an increased clinical demand in the speciality that impacted on consultant workload. This usually resulted in waiting lists to see the consultant which increased the time patients had to wait for their first appointment. As identified in the previous section, this opportunity to help meet the clinical

demand and the motivation of the participants to have an extended role created a situation for change to occur.

At the beginning of their ESP careers it was the consultant who provided the means of acquiring the technical knowledge and skills required for the new role. It was only through working with the consultants that the participants learnt their new skills and could practise. The medical establishment provided the gateway and controlled the transfer of skills but only allowed this, as we will see, if it suited their agenda, reduced their workload or was not seen as a threat to their area of work.

In terms of acquiring the knowledge and skills Participant C described the importance of consultant support.

“I think in terms of developing your extended scope practice you need someone in the medical profession to give you the training and the guidance and to help you develop.”

Even later when the participants were experienced in their clinical speciality, and had completed post graduate training at Master's degree level (which supported the role academically), they all identified the importance of the training provided by the consultant.

“The consultants are very good at teaching within the clinic. We have very open discussions...and we have this type of system where we discuss the findings of our assessment and discuss the reasons for what we are looking at. We look at MRI scans so the consultant does teach a lot within the clinic.” (Participant F)

Participant H, even after 15 years in the role and a Master's degree in the clinical subject, still highlighted the ongoing support from consultants. She still sought advice or reassurance from consultant colleagues in complex cases.

“We will every so often go and spend a morning in our consultants' clinics. They are just the other side of the wall. So, if we have a patient that we want to discuss, off we trip with the medical notes and say we done this, we done that, we said this, what would you have done?”

Participant B described the importance of understanding the consultants' clinical views, and their way of approaching patients, in developing the ESP role.

"I progressed through talking with the consultants, looking at how they would look at things and what they would look for. Whether a joint (sic) was not yet ready for theatre and what I could do to prolong that. Sitting in with the consultants, looking at their assessments, so that you are looking at various things and building on that."

The consultant led education seemed to structure and define the boundaries of the role. The participants described how training with the consultants gave them an insight into how "their" consultant made decisions and what he (or she) would do in certain clinical conditions. The consultants provided the training and in doing so shaped the practice in these roles. In discussion with the practitioners they were keen to point out that they were not simply passive recipients of the consultant's knowledge. They actively co-created the role with the consultant based on their ambitions and supplemented this with other external training or higher degrees. Participant D described how this occurred.

"Most of the changes have been supported by the same sort of desire and interest from a consultant backing point of view. There has been experiential learning but we've created a distinct sort of packages of learning so that we have a training program, framework & sign off. So, that everybody knows what they're doing and how it's been done to the appropriate examined and tested level even if it's only been tested internally."

This framework described by Participant D related to the clinical competencies of the participant which were formally acknowledged by the consultants in a written document. Participant D argued that it was his way to ensure that he could demonstrate competence in his new clinical skills. However, as Morris et al (2015) point out this sort of framework only meets local requirements. The nature of this in-house extended physiotherapy training meant that few ESPs could work in this same role across other hospitals as their skills were not likely to be recognized as a formal licence of competency.

This reliance on the consultant for training and acknowledging competency has been found in previous physiotherapy studies (Atkins 2003, Dawson and Gharzi 2004). In terms of physiotherapy and the NHS this is not unique and has been reported in Australia (Saxon et al 2014, Morris et al 2015) and Canada (Desmeules et al 2014) where physiotherapists have taken on ESP roles. This seems set to continue as, despite the experience and seniority of the participants, none were involved in training other physiotherapists in their role. Further, the latest CSP guidance (CSP 2015) on developing extended roles (in this case epidural injections) states that this can be within a physiotherapist's scope of practice if appropriate training has been undertaken. However, more importantly it needs to be included in the practitioner's job description and the employer must specifically take vicarious liability. In other words, the employer is responsible for training, competences and accountable for the physiotherapist's practice rather than the physiotherapist's professional organisation. As the knowledge, skills and training are delivered by the consultant it reinforces the consultants dominant position in healthcare. Equally it raises questions about the role of the professional body. It may be that the CSP is risk averse and fearing litigation will not insure a relatively small number of practitioners engaged in innovative practice. Or it is waiting to see if such practice becomes accepted and common place before committing the resources of the CSP to advocate the new skills as physiotherapy. What becomes clear is that change is occurring at the individual level.

The individual development of these posts was further highlighted when Participant L was asked what would happen if she left:

"There would be a gap."

Participant K also reflected, during conversation, on what would happen if she left.

"There is nobody to take on the role, so I don't know really what would happen."

In the case of Participant I, some thought had been given but no decisions or actions had yet been taken.

“There is an on-going discussion that I've had with my manager that we should think about succession planning.”

Participants A-D, G, H and J described how there was a general interest in their roles from other physiotherapists but to date no further roles were being created. Participant D hoped that because of the framework he had created with the consultant the next ESP would find the pathway easier.

“I would like to think it would be easier for them because I've had to find out how to do things, and perhaps learn along the way how not to do things, and there's a process in place. It's almost a tried and tested and effective and safe process, has stood the test of time. and work through large number of patients and I think that reassures medical colleagues quite a lot. It can work it can be done generally speaking and there is a framework in place.”

Kitchener and Mertz (2012 p373) in investigating change in American dentistry identified that change in the autonomy of dental hygienists and independence from dentists in California was in part enabled by what they termed “producing the producers (education) and monopolising professional knowledge.” There was a need to establish the technical ability to practise independently. A critical component in creating an institution (or changing an existing one) is the education of its actors in the development of new skills and knowledge to support the change (Lawrence and Suddaby 2006). The participants identified the lack of an educational strategy to support their roles from within the physiotherapy profession. They were reliant on the education and support of consultants to acquire the relevant knowledge and skills as Participant D acknowledged.

“There is no obvious CSP structure career pathway for the development of my role. There is no set of competencies as such.”

Such findings have resonance with the original conclusions of Gharzi and Dawson (2004) a decade earlier. In that, providing the means to reduce the consultants` workload created the opportunity for the participants to change practice. Nancarrow and Borthwich (2005) argue

that it is common for dominant professions to discard unwanted roles during times of prosperity or high demand while also maintaining a degree of supervision over the work and practitioner. This was one of the enabling factors in establishing the ESP role. However, even in times of high demand there can be specific occasions when a conflict of interests between professions has a greater effect than demand. In such situations, this usually results in change being opposed.

The participants experienced occasions when their suggested role advancements were actively discouraged or blocked by the medical consultants. Participant F explained that his attempts to set up an independent clinic running along-side the consultant's clinic was blocked by the medical team.

“There was a lot of resistance from the consultants to do that and at the time they were pushing for a new registrar’s post and felt that as part of their business case a registrar would take the second clinic. So, we now have two doctors in clinic, the consultant and specialist registrar and (yeah) so the separate physiotherapy clinic which I think would be a good and cheaper option and extension to my role is not being pursued.”

Even after three years Participant F still felt there was a tension.

“Generally, yes there's been a tension in trying to push for a physiotherapy clinic and he didn't want to do that because they were pushing this business case.”

Participant B found a solid barrier and resounding no when suggesting that her role could extend into minor surgery.

*“There has been a definite no on ***** (deleted to maintain anonymity). I'm not sure whether it was a perverse incentive because the ***** were being done in the private sector at a phenomenon rate. Whereas I was involved in a business case with one consultant where we could have done it (actually) a lot cheaper, and we went to see an area of expertise where a theatre sister was doing it. But it was a definite no-no and I have to say that was probably a step too far for many of them.”*

In both cases, it appeared that the expansion of the physiotherapy practitioners' roles would have put them in direct competition with the medical body, or created a change of professional boundaries which the medical establishment were not willing to relinquish. The outcome was the same, both new roles were stopped. As Participant E succinctly put it in trying to change, *"It's not going to be acceptable to my consultant colleagues because it's taking some of their jobs"*

Participant D, after a reflective pause of five seconds, discussed his perception of trying to instigate change and the reasons why he believed it can sometimes be difficult.

"Part of it is overcoming the, the resistance to change in a traditional model of care delivery. Not that people are unwilling to embrace change but it seems to be a huge effort to instigate change. It seems to be quite hard to get people from outside of our profession to embrace the ideas of the benefits of our services that can be delivered in a slightly different way..... I think sometimes there is a reluctance amongst people, particularly in the medical fraternity, whilst they are very keen to promote development when it suits their purposes, I think there is also an issue that sometimes when they see a role being delivered well I think they are sometimes looking over their shoulders to see what is going to be taken off them next."

Participant D reflects the comments of Hargreaves and Van De Ven (2010) when they suggested that effective action needs to recognise the interdependence of incumbents' (in this case the consultants) and challengers (the ESPs) and exploit actions that can be mutually beneficial. The participants realised that the consultants were also experiencing change and, within this evolving environment, timing of developments was important. Participant F had not given up his aim of establishing a clinic and was using the financial challenges within the hospital to argue his point.

"We are currently looking within the trust for efficiencies and savings...I have identified in papers changes in areas to make them more efficient."

The power and influence of medical consultants still played a significant part in the continued development of the practitioners' role but in recent years the impact of financial constraints and cost savings was also having an effect. The participants realised that hospital managers were another group that could be used in negotiating ESP roles and as an additional resource when negotiating with consultants. Koelewijn et al (2012) in a systematic review of the dynamics of hospital managers and consultants within hospitals in Western countries found that consultants' dependence on hospital management had increased along with health care reforms and the resulting emphasis on business logic. They found that consultants had to adapt to these pressures to maintain their traditional dominant position and professional autonomy. In doing so an inter dependence between the consultants and the hospital managers developed resulting from the increased dominance of the business-like health-care logic. The participants also developed this logic which can be identified in the business orientated language used in discussing their relationship with hospital managers and describing the economic pressures within their organisation.

6.3.3. Negotiating with Hospital Managers.

A central motif of health reforms around the world has been the drive to persuade doctors and other clinical professionals to become more actively engaged in the management of services. Examples include moves to extend the commissioning role of primary care doctors (such as general practitioners in the UK) and the introduction of 'clinical directorates' in secondary care (Kirkpatrick et al 2012). The participants in this study were actively engaged in the management agenda because it provided a further opportunity to push for change.

Participant B identified that health service managers were being driven by financial pressures within the hospital. This provided an opportunity to discuss with the general manager the advantages of her role as she explained.

"It's only because of let's say the financial situation that's worrying that they are now being proactive. They are seeing the benefit of the role largely by the work that, not just myself, but

with other colleagues have done to say look this is what we could do for you. It really is a money-spinner. We are cheaper to employ we can do it and so therefore we don't need to employ as many doctors."

Participant F picked up on the new role of hospital managers and used this to push for change and challenge the consultants. The discussions with the hospital managers were based on the efficiencies and effectiveness of ESP clinics as he elaborated on his argument.

"I strongly believe that that is one of the areas that can be changed easily and made much more efficient and have almost a cheaper service for the hospital and the trust. I see these clinics running alongside the consultant's clinic. From the perspective of the paediatric management, the directorate manager would be happy to do that and that's something that I'm thinking of pursuing. I'm just starting to meet with her a little bit more. But I got time constraints at the moment. So, it's choosing my battles at the minute which one I'm going to fight."

Several of the participants described engagement with senior managers and commissioners to explain the benefits of their role in business terms. Kuhlmann et al (2013) argue that incorporating management thinking into professional self-governance creates a hybrid model of professionalism which combines the management features of cost effectiveness and efficiencies with the clinical qualities of patient care. Having a business logic enabled the participants to influence health care managers by having a common language.

Participant J identified that the fear of losing clinical business to other hospitals was an incentive for hospital managers to work with extended scope physiotherapists to ensure waiting times were achieved. She described the discussion with managers in the following way.

"We don't want our patients to go to xxxxx (deleted). So, there's a big push to make sure that the patients get their appointments earlier than they would at xxxxx. There is already been a suggestion that we develop and put in an extra ESP clinic a week to make sure that patients

are seen quickly.....I think the time when the doctors could say yes will have you or no we won't, I hope is moving away, because I think managers can see that there is a cost effectiveness in having a physiotherapy ESPs then having medical sessions so I think that whereas before we were there by their grace I think probably that will change because it has to change."

Nancarrow and Borthwick (2005) argue that dynamic role boundaries have the potential to challenge the monopoly of all health care professions. They suggest that managers are using their control over resources to change how services are delivered including changes to which profession provides services for certain groups of patients. Correia (2013) identified in a study of consultants' relationships with managers that there was no one approach but there was an emphasis on maintaining the status quo and their mutual positions within the organisation. As the participants found, from their experiences, the influence of hospital managers was context specific and depended on the current situation and pressures.

Bourgeault and Grignon (2013) concluded in their analysis that the cost of health care in the UK was too high to be left under the control of professions alone. They argue that a market orientated system seemed to have a better ability to promote inter-professional and team work between doctors and other health care professionals and that a health market economy "can overwhelm medical dominance under a wave of allied health professionals supplying a close substitute that can be chosen freely by plans reflecting consumers' preferences." (p 219). This business logic within the NHS was recognised by the managers, consultants and participants.

For every change suggested by one group there was an alternative suggested by others. This is demonstrated by Participant J description of current situation in Rheumatology and her perceived outcome:

"We had three rheumatologists and we have one rheumatologist who is semi-retiring and we have one rheumatologist that has left. So, they will (the rheumatology consultants) put their business case in that we need these people replaced. The managers have said, well should

we be replacing all these with medical hours or should we be looking creatively at roles like this. The rheumatologists know that they are being pushed down that route so they have tried to bargain and say if we say that we will have to have one full-time rheumatologist rather than replacing the old two. If we have a full-time rheumatologist, then this will then enable us to support the other kind of role.....I think they're sort of hedging their bets. S,o okay we will have one (an ESP) if we absolutely need to have one and if it's XXXX (removed for anonymity) or nothing that will have XXXX but if there is a possibility that we can get medical hours instead of XXXX then we will go with the medical hours”

Participant K was having similar discussions with managers but felt that there was an aversion to having less doctors.

“I don't know whether the trust would ever go down the route of having less doctors because the physios are doing the clinics”.

The participants were aware that, although they could get support from the management team for their roles, they still had to work with the consultants as Participant F explained.

“I think that if you can justify any changes, then that obviously helps, with the management and their acceptance of a change and if they can see a financial gain which I'm sure there would be then that would be a support mechanism and they would help me push that with the medics. Because obviously, the medics are much more managed than they used to be so maybe that's one area where I could gain support from. But you don't want to push things and keep get people's backs up with regards to the medics and do things without their consent because we do work very closely within the clinics”

However, what the experiences of the practitioners did illustrate was how their professional project of extending their role was surrounded, encouraged or constrained by broader institutional projects pursued by other stakeholders. As Zietsma and McKnight (2010) argue, creating new roles is unlikely to be winner takes all. There will be collaboration, co-creation and competitive convergence to ensure that the interests of various actors will be embedded

in the new institutional arrangements. This is illustrated in the ESP negotiations with other healthcare professionals which is discussed in the next section.

6.3.4. Negotiating boundaries with Non-Medical Health Care Professionals

While looking for support from managers to extend their roles into previously perceived medical practitioner territory the ESPs were also creating professional boundaries with other health care professionals in the same clinical area. Participant L wanted to make clear how good the working relationship between the clinical specialist nurses and her clinical role was on a personal and professional basis.

“I think there is some overlapping in what we do but I think we are all aware of what our roles are. We respect one another and I think we work very well together. That's what happens in this post and definitely happened in my last post. I think that as a specialist within the field you can justify to another profession why you are doing something and because we are so autonomous we can justify what we are doing with our patients and we get along, as long as we make ourselves clear, I think other professions are aware of that and I think that works well for a really good working relationship.”

When asked what other extended practice, she saw herself developing soon she suggested being able to prescribe medication would be a distinct advantage in the role she was providing and

“That would make a seamless service for the patient.”

However, when asked why that was not happening she replied after some thought.

“I think because the nurses have such a big role in that. I work with two nurses who are prescribers. So, it's quite easy to access their services and for them to assess my patients

and for them to deal with that and so I'm lucky that I have those people in post that I can call on, rather than referring to the GP or to the medics, whatever, the nurses do take on that role."

Whether Participant L will push this boundary was uncertain but on reflection she identified a self-imposed clinical boundary which fostered the working relationship between the different professions in the same clinical area. However, she was keen to point out that taking on such a role would not affect the professional dynamics.

"I don't think it would upset the relationship. I think they would be quite happy for me to become a prescriber. I don't think anybody would have a problem with that at the moment, so I suppose that's just something that I would properly want to take on in the future. But I don't see a problem with that."

Participant K, worked on a unit with a multi-disciplinary team of extended role practitioners. She identified that it was this working together for a long time and knowing each other which allowed skills to be shared and roles negotiated.

"I think that's worked really well because it's been sort of mutual thing, you know we've got clinical specialist nurses who've taken on roles that they would never done before for instance putting in long lines. They have done their prescribing course as well. So, we run along together. Everybody complements each other and I think because we all work so closely with the same client group often it's often whoever's there and the most timely as to who does what job."

However, having completed a supplementary prescribing course Participant K found that her ability to practise was restricted due to other professional groups also being able to prescribe. She described how her additional skills impacted negatively on the care of the patient.

"As a supplementary prescriber, because there are doctors here all the time, it has not shortened the patient journey. It has added to it because they are not happy for me to prescribe anything and everything. You know I have very strict guidelines on what I can prescribe. So, let's say that a patient comes for a test dose of a nebulised antibiotic, which we do, I can

prescribe them that but I cannot prescribe the oral antibiotic to take alongside it which they need. So, the patient needs either two prescriptions, one from a physio and a doctor or one from a doctor.”

These internal guidelines were drawn up by the consultants on the ward. Participant K could not hide her frustration.

“And I think the joke is, I actually ask, tell the (junior) doctors, what to write on the prescription anyway.”

This outburst has a similar pattern to Stein (1967) seminal paper on the doctor–nurse relationship where dominant male doctors, responsible for diagnosing, operating and prescribing, were being covertly guided in clinical decisions by apparently acquiescent female nurses, supposedly responsible only for ‘housekeeping’ and patient service.

Asked why she thought these guidelines were in place she believed that it was a lack of understanding about her role and what she could successfully clinical manage as she explained.

“I think some of it is ignorance of how physiotherapist sits within the clinics and fear really, I think, from some other doctors.”

She was confident that this would change. However, there were also nurses with prescribing rights and Participant K confessed that she was wary about encroaching into their clinical area.

“The nurse prescribers have been doing this a lot longer and have specific groups of patients that they deal with.”

Instead Participant K found her own discrete clinical area working with a pharmacist on medicine reviews with patients. This conscious decision to avoid encroaching on another profession’s clinical area was described by many of the participants even when they believed they were the better profession to provide the service.

As an example, Participant B provided follow up clinics and yearly reviews for some patients following hip or knee replacements (arthroplasty clinics). Other similar clinics were being provided by nurses. She described how she and another colleague decided to “share” the role, avoid confrontation and manage the tensions.

“I suppose one of the areas that I would have like to have really, not for me particularly but, would have like to improve is the arthroplasty side. I get on with the arthroplasty nurses, we get on I think because we’ve known each other for a long time and we have offices opposite one another and we have been able to go in and see one another and they are happy with me but they are very protective and I think they think that people will come in and take it off them so you have to be aware of that.”

She decided not to push her role, or advocate another physiotherapist taking on the role, because she wanted to avoid a potential conflict. In doing so she preserved the current working relationship. However, if the arthroplasty nurses left she was keen to offer her or her physiotherapy colleagues services to replace them. Kroezen et al (2014) describes the situation and outcome in the Norwegian health service when nurses were given independent prescribing rights. Legally, within a national framework, nurses were given the same autonomy as consultants in prescribing. In practice, the nurses and doctors came to arrangements in the workplace which created boundaries and working practices that were acceptable to both professions. The emphasis from the ESPs was arriving at a negotiated settlement with the other professions. As Svensson (1996) observed, negotiations more commonly occur when policies and rules are not in place and working agreements are needed which are mutually beneficial.

However, arriving at a compromise and agreement was not always possible. In some areas competition for clinical dominance became apparent. Participant H vented her frustration and disappointment in contrasting her relationship with hospital nurses and nurses in the community. There had been discussions with community services about out-reaching hospital services into local health centres staffed by extended scope physiotherapists and nurses. The

professional staffing of the clinics was expected, by Participant H, to be the same as that within the hospital but all did not go to plan as she explained.

“We talked about going into the community, okay, because there is no community equivalent. We have community continence nurses and we have had on-going discussions over the years about them funding a community physiotherapy service. Never any money, never any money and then I had an email last week to say they are getting five new staff nurses and yeah what happened to the physiotherapist you always said you needed?”

Her frustration and anger at what she saw as a lack of professional recognition was clear in her tone of voice. What annoyed her most was the fact that the nurses were going to practise some of her key physiotherapy skills as well as some of the new skills she had developed. She contrasted this to her experience with hospital based specialist nursing staff. She truly believed that the venture in the community would fail (or hoped that it would) because they did not have the clinical knowledge and expertise of physiotherapists. She described the contrast between the two groups of nurses.

“Our nursing colleagues here, it would never cross their minds and they would never entertain doing any of the treatment we might use. They wouldn't entertain it! But in the community, they have done this. The majority of staff have then had to hold their hands up and say we don't have the knowledge or expertise and we would rather pass the patients on to you.”

Asked about why nurse specialists in the hospital would not consider taking on the physiotherapist's role Participant H gave a considered response.

“We don't get involved with catheterising patients that potentially we could but we don't. We respect that that is their role. From a workload point of view, we would not want to take on extra responsibilities that we don't need to take on because we don't have the capacity to do it. We are not fighting for work we have found that there is more of a flow of referrals from nurse to physio than from physio to nurse.”

The practitioners established a mutually supporting status quo in the hospital which they were not able to replicate with the community organisations.

This difficulty of establishing negotiated roles and boundaries with different organisations was also described by Participant I. He described the situation with physiotherapy colleagues in the community (PCT) and the failure to find a negotiated agreement

“One of the things that I was involved in earlier this year, no last year sorry, was a pathway for patients within xxxxxx (removed for anonymity). A pathway for any knee problem. So, I was involved with in those discussions and trying to make that work more effectively, efficiently. Because that was PCT driven and because I work within the acute trust I feel that I don't have as much ownership of that and as much contact with that process as I would like. And again, it is that constant sense of frustration on my part that we have the two systems that operate very separately. They don't talk to each other anywhere near sufficiently enough.”

Again, this demonstrated that negotiations cannot be divorced from the structural and social conditions in which they are made and the settings where they occur (Straus 1978). Participant I was frustrated that the community team failed to recognise his extended role and clinical skills. Further, the PCT were going to develop their own practitioners that would be in competition with the acute hospital and Participant I. This illustrated how the broader and more powerful institutional arrangements stifled the ability of the participant to act. The individual becomes shaped or adapts to the institutional pressures. In some cases, the dominant position of another profession or individual minimised the participant's motivation to act because of the likelihood of failure. This is best explained by Participant A when she describes her reluctance to make closer links with community services.

“There is a very, very experienced specialist nurse out in the community.....I don't think we will ever have such a major role that she has. She has a very, very good reputation. And although we do a little bit of work with the colorectal surgeons they will always refer to her and I don't see that changing.”

The physiotherapists worked to establish boundaries and referral pathways but so too had other professionals. The strength of these professional relationships and reputations ensured that the practice boundaries prohibited others from entering the clinical area. The participants were aware of this and focused their endeavours on where they could bring about change.

Participant G demonstrated another way of breaking the tension while reinforcing his own clinical role. He argued that there was an obligation to work with other staff even if the patient had been transferred to another organisation. He described his reasoning in the following way.

“It is in our patients` interest, even though they are not our financial responsibility, they are our moral responsibility we should also give the staff the opportunity to tap into your expertise and help them with their development.”

He began on an informal basis working with professionals in the community team identifying clinical training needs and providing an in-service training programme. This ad-hoc arrangement later became a formal training contract between the two organisations and the hospital charged for this service. This cemented the position of Participant G as an educator as he explained.

“So, I do 8 half day sessions a year with the therapists in the community rehabilitation team”.

In doing so he fostered links with other teams and established his role, or recognition for his role as an ESP, with another organisation as well as maintaining his role within the hospital. Perhaps the most common way of establishing boundaries and new roles with other professions was being the first to seize the opportunity. Participant H highlighted an opportunity to expand her roles within a clinical speciality not currently within her remit.

“There is a person who does our investigations at the moment who comes from a medical science background rather than nursing or AHP but is coming up for retirement but hasn't decided when she might go and there is no succession planning really in place. And one option is that, we take the role on as well.”

Participant H identified her motive in the following way.

"Nobody from a gynaecological management point of view seems to be planning what's going to happen and that's a frustration. As physios we like to plan we do like organisation and we look to the future. The doesn't seem to always happen in other professions in quite the same way."

Her words echo the description of physiotherapists by Parry (1995 p310) "as doers who solve problems as they arise". Participant H planned to put herself and physiotherapy colleagues forward to the general manager for training and the solution to the problem. The additional physiotherapy support would be funded from the retired post-holder's salary at a lower band therefore backfilling the physiotherapy post and providing a cost saving. The reason she was confident that the nurses in the department would not have a problem with this was there was enough work and scope for each discipline.

"I think that if we were fighting for work it might be different."

Participant A summed up why ESPs continued to negotiate change.

"We're motivated and see the opportunities to extend patient care in areas we care about"

Recurrent throughout the theme is conscious and pragmatic decision making. The decisions on where to establish their roles within the organisation, where to compete, where to co-operate and when to stand back illustrates Lawrence and Suddaby's (2006 p 219) notion of institutional work as "intelligent situated action" by reflexive actors negotiating their environment. Abbott (1988) argued that professions engage in jurisdictional disputes in which occupational vacancies are created and occupied in a dynamic and inter-related system. Inter-professional conflict was at the heart of the system. However, in this theme, there are more features of jurisdictional accommodation and a distinct lack of overt conflict. What became apparent was the motives and intentions of the actors involved to extend roles but also conscious decisions to maintain a harmonious working relationship with other health professionals.

In most instances changes were negotiated. The participants agreed their working roles with others to foster a good working relationship. The amount of time the participants and other professionals knew each other helped to create this relationship. Sanders and Harrison (2008) suggest that working in spatial and temporal proximity has the effect of reducing overt conflict. In addition, these changes occurred during a period of increased clinical workload and demand. Nancarrow and Borthwick (2005) contend that increased demand presents an opportunity for workforce flexibility and legitimises the blurring of professional boundaries by endorsing vertical and horizontal substitution of roles and tasks.

Suddaby and Viale (2011) argue that professionals adapt to working in large bureaucracies by developing an ability to conform to the pressures of their employing organisation while simultaneously using the organisations resources to meet the demands. In doing so they produce change to the benefit the organisation's agenda but also the agenda of the professionals. The experience of the participants gives examples of this negotiation using the business language of the organisation which compliments their own drive and ambition to extend their clinical knowledge and role in a clinical area they are committed to.

There have also been examples of frustration at the lack of opportunity for change. The participants' reasons not to vent these frustrations were either political (so as not to cause friction at this time and maintain the status quo) as in Participants B and D in not challenging the consultants. Pragmatic reasons (as to wait for a more appropriate time to push for change) as in Participants J, L and F deciding which battles to fight. Or a lack of opportunity or agency to create change (the decisions made by neighbouring NHS organisations in which they had little influence) as with Participants H and I and their relationship with community services. This confirms Allen and Hughes (2002 p19) assertion that "Inter-professional relations are a crucial area in which the existing divisions of labour is sustained, and is changed over time as new levers are brought to bear." The experiences of the participants demonstrate the dynamic and political nature of change and the need to be sensitive to the context in which this change might or might not occur

The final theme examines the participants' experiences of NHS change. The ESPs discussed the opportunities and threats to their roles with the changes that were occurring within their organisation. They shared their thoughts for the future and how they might achieve them. It also provided an opportunity to reflect on what they had achieved.

6.4. NHS Changes

6.4.1. Introduction

The interviews with the participants were conducted in 2012 and so the impact of NHS change and hospital pressures relate to that time. The experiences of the participants reflect these changes and their concerns or ambitions for the future. The participants were aware of, and experiencing the economic and political pressures within health care. They articulated their fears for the future and how the role (and by implication themselves) would fare in the uncertainty within the NHS. This theme captures the tension between the individual undertaking the role and the sustainability of the role itself in the future. It throws light on how change brings with it the opportunity for further adaptations and expansions but also the risk of enforced change and erosion of the role. The participants discussed their mixed emotions about the current situation and their hopes and fears for the future.

6.4.2. Change

This uncertainty felt by the participants highlights what Adler and Kwan (2013 p955) describe as a “top down, bottom up process” where change is simultaneously occurring at different levels within, and between institutions, without an agreement or understanding on the process or outcomes. While the participants were engaged in change they were also subject to downward influences of macro-economic policy and ideologies such as market competition and multiple providers of health care. At the same time, they were subject to the organisational pressures from within the hospitals to reduce costs and meet increased clinical demand. They found that the institutional framework that protected professionals from the rigours of market competition was being dismantled (Speed and Gabe 2013) and they were being drawn into a race of competitive advantage and commercial values.

All the participants were employed by acute hospital trusts and developed their roles within a hospital environment working with medical consultants. At the time of the interviews their

concerns came from internal changes within the hospital and external changes occurring within the community and how these would affect their role. Internally participants reported hospitals conducting skill mix reviews and service reviews with an emphasis on cost reduction. Externally the primary care trusts were concentrating on moving traditional hospital outpatient services into the community. The development of increased patient choice, over where they wanted their treatment, greater autonomy for providers, and a payment system in which funding followed patients created an environment for competition between service providers (Niemietz 2015). Starting within the hospital the participants talked about the changes, the personal impact and the ways in which they were likely to deal with them.

Participant C had recently taken on significant additional tasks and responsibility for a research project within his extended role. He had considered asking for an increase in salary in terms of grading to reflect this extra responsibility but decided not to pursue this course of action for the following reason.

“I think that is partly my decision, as at the time I didn't think it was an appropriate step to take in that there were lots of other staff being downgraded and changes within the service structure so I was happy to defer that process until things had settled within the new structure.”

When asked how his request for a re-grading might be welcomed he replied ruefully.

“I don't know really. I would imagine that it won't go down well because the organisation is under considerable financial strain but I've worked for the organisation for over a decade and a half and it's always been under financial strain, so for me it's status quo.”

For Participant C one of the ways to maintain his position was to take on these roles at no extra cost to the service and in doing so consolidate his position. In conversation with all the participants they were mindful that one of the attractions of their posts, from a hospital management point of view, was they were cheaper than a medical consultant and could deliver some of the consultant's workload effectively as Participant B explained.

“They are seeing the benefit of the role largely by the work that, not just myself but with other colleagues have done, to say look, this is what we could do for you. They should be looking at it really, surely, from a money-spinner view. We are cheaper to employ, we can do it and so therefore we don't need to employ as many doctors. I think that in the role they get value for money and that has to be one of the overriding considerations in this climate.”

This view point was echoed by Participant K with one caveat.

“I think what might save us, if you like, is that we're cheaper than doctors and with our extended roles there are things that we can do equally as well as some doctors. I'm not suggesting for a moment that we are working at consultant level at all but I do think that we could easily run our own clinics and not have to have the doctors there. But I don't know whether the Trust would ever go down the route of having less doctors because the physios are doing the clinics”.

Participant D believed that ESPs could be part of a solution to the financial pressures and clinical demands of the hospital but was not convinced that hospital managers were bold enough to implement such change. There was, he believed, a need to re look at the model of health care delivery but, as he went on to elaborate, this may not happen in the near future.

“I think we are a huge untapped resource. I think that people can work to a higher level, safely and effectively, adopt proactive change and are not shackled by traditional models of healthcare. Upgrading people to a reasonable level great takes minimal financial resource whereas trying to keep consultant medics in similar positions is very expensive.....but I don't see any great likelihood of anything changing in the next two or three years in terms of, certainly the trust in which I work, changing its attitude and making these opportunities available and I'm not really sure that the NHS as a whole is embracing the idea of AHP's and extended Scope as fully as it should.”

Participant D echoed a commonly accepted view that despite providing evidence as to the effectiveness and efficiencies of their roles they believed clinical services were still focused around medical consultants as he explained the current situation.

“Some of it is organisational inasmuch that when there is a vacancy freeze everything gets frozen but consultant medics can be parachuted in left right and centre at massive cost. The answer to everything seems to be if we haven't got enough staff we need more consultants and then the support staff that allows the consultants to function and discharge their duties is never thought about. Everybody is expected to do more with less, I'm not sure that many organisations have the appetite to challenge the medical status quo.”

Participant J tempered this view slightly by referring to market forces which also impacted on consultants.

“I think here in paediatrics it will probably expand in terms of the sessions that I do because here at the trust we don't want our patients to go to XXXX (removed for anonymity). So, there's a big push to make sure that the patients get their appointments earlier than they would at XXXX..... the time when the doctors could say yes will have you or no we won't, I hope is moving away. Managers can see that there is a cost effectiveness in having a physio ESP then having medical sessions....”

Or as Participant I summarised.

“It's all about money, it's all about money.”

The participants` perceived that the consultants still held a powerful position but there was more acceptance of negotiating agreements. Like the findings of Currie et al (2012 p 958) rather than absolute resistance to change consultants engaged in the process that “shaped the change trajectory to ensure professional dominance”. While the participants were engaged in negotiation with hospital managers the hospital consultants were doing the same. Each may have conflicting perceptions of institutional deficits and differing needs to build new institutions, or maintain existing ones (Helfen and Sydow 2013) but in entering negotiations there is a need

to recognise the competing institutions. The consultants were aware of the participants and their role and the wider health agenda of value for money and patient choice. As Hargreaves and Van de Ven (2010) point out effective institutional actors whether established, like the consultants, or challengers, like the ESPs, act to stabilise or change the institution by using the tensions between contradictory elements.

The participants found their argument of providing value for money was a double-edged sword. While they were cheaper than medical consultants they were more expensive when compared to other professional groups particularly nurses. All the participants in this study were graded at band 8a except one who was graded at 8b (see paragraph below for details). Their nursing colleagues in specialist roles were graded significantly lower as Participant H pointed out:

"I think it's an issue in our department because of the way we were all graded under agenda for change. In that specialist physios came out as 8a whereas specialist nurses that we work with came out as band 6. We obviously have professional differences in what we do but there are also a lot of similarities in what we do and when we were first banded it was difficult."

Agenda for Change was a national assimilation of NHS pay scales (excluding doctors and dentists) with several objectives, one of which was to ensure equal pay for work of equal value (DH 2004d). Pay bands were graded one to nine with band 8 further divided into a,b,c and d. Band one was the lowest pay scale with band 9 being the highest. There is a difference of thirteen thousand pounds annually between the top pay scale of band 6 and the top pay scale of band 8a. Most of the participants managed this situation by not disclosing the outcome of their grading to nursing staff as Participant A explained.

"We were all banded at 8A's and yet there are nurse practitioners here doing what are probably similar roles who are being paid at band 7. So, that was one of those situations where, in physio we've probably kept quite quiet about it and probably the nurses have no knowledge that we're working at that level so that there is no potential tension."

However, these pay disparities were now being identified in service reviews within the hospitals. Participant K suggested that this was more sharply focused because many of the managers conducting the reviews came from a nursing background.

“Yes, I think that we are at risk because we are expensive or we are perceived to be expensive, especially in this Trust. I think the management structure is such that most of the managers within the Trust are nurses by background and the nurses came out quite badly on the agenda for change at least a grade below us at each comparable sort of level.”

All the participants felt under scrutiny and were carefully considering what the future might hold for them and the role. For some there was an expectation that the role might not continue. This was very personal to the participants and in interview they showed their emotions. For some there was a degree of frustration that their endeavours over the previous years were somehow undervalued. For others, some who had gone through change before, there was a degree of stoicism in that what was going to happen was going to happen.

Participant G made this point in relation to his role and the current review of clinical services.

“I know that at this current time because we're still in the review period, my role has been questioned and may be struck out by higher level managers. Okay. Not by my physiotherapy managers, who are, who have put forward now I know is there are three or four different versions of a plan (yeah) that I have been factored into. Okay, but the ultimate decision will rest with division management. Okay, they could well look at the structure and say what does this person do and of course there looking at the larger salary people and so it is the 8b's and the 8a's and the 7s who are most stringently been looked at. They could look at that role and say, just tell us again what that person does, okay, right that's a role you can do without.”

This was not the first-time Participant G's role had been reviewed but, even though he had produced evidence for the effectiveness and efficiency of his role, he believed that with only a few years left until his retirement the role was unlikely to remain.

“But because my role has in the nearly 20 years that I've done it, I would say it has been reviewed on this basis probably at least three times before. Okay, but this is the most severe type of cost-cutting that going on, that everybody nationally is aware of. Okay, so I would say that this is the biggest threat and because it's been questioned so many times before, even if it survives this time I am fairly certain that it will disappear when I retire anyway.”

Participant E, also felt that her role might not withstand their organisations review but she was considering alternative options if this occurred.

“Currently my role is being challenged as the Trust is having a restructure and they are looking at the roles of all physiotherapists and the Trust wants to have more for less. I think that there will be more people working privately and with any other qualified provider it will be down to GPs,”

The main consensus from the participants (except Participant G) was that the posts would survive but possibly at a lower pay grade or they would be expected to do more at their current grade as the following participants pointed out.

“I think I'll probably be doing the same role at the same pay grade but probably with more responsibility.” (Participant D)

“I certainly wouldn't be surprised if we are downgraded, but as I said earlier if that happens, it happens.” (Participant A)

There was a feeling of frustration and being under-valued in their roles but also a realisation that this was happening to everyone. The two reasons why they believed their posts would continue (maybe at a lower grade) were summed up by Participants L and C. Participant L argued that new clinical guidelines and guidance would support the role.

“I think that there is a degree of uncertainty but I feel quite comfortable in what I provide because of the evidence background and the new service specification that came out. This

was a department of health document and I think helped us, secure in the fact that it is evidence based and what we provide is proven to work and also the NICE guidelines.”

While Participant L based her argument on clinical guidelines Participant C pointed out the practicalities of finding someone else to do the role and take on the workload. Returning the workload to the consultants would not be popular and they may not be able to take the extra work. The impact of not finding someone to do the work was a large waiting list which would impact on the hospitals` targets and income as he went on to explain.

“I think that in the future if I was to leave now, next week, I suppose it's like anything there would be a gap and like most things in the NHS they would look at it and see if somebody could do it at a lower grade. Do we definitely need that person? Can we do it without? But I suppose the thing about having an ESP, consultant role where you have discrete clinics and you are doing a volume of work and everybody is quite strict about job plans. It will be a matter of finding six clinics a week to distribute amongst the rest of the team. They will may alter the grade or change some aspects of it but I think you would still need a similar role in future.”

(Participant C)

Yet throughout this period of uncertainty within the hospital the participants were looking for other areas to practise their roles and all of them considered primary care. They saw opportunities to develop further and create a new service in a new setting. They were also aware that this might bring with it difficulties as they discussed adapting to the current situation in this next section.

6.4.3. Adaption

Throughout their interviews the participants demonstrated a knowledge and understanding of the prevailing business culture and pressures facing their hospitals. They incorporated this business logic into their perceptions of the role and used this to discuss how they would manage and adapt to change. This extended to possible opportunities in their local community

services. Participant A, in conversation with her physiotherapy manager, had identified a gap in the community.

“We talked about going out into community, okay, because there is, there is no community equivalent.”

She was in the process of writing a business case to present to commissioners of services based on a defined clinical area of need which could be effectively dealt with by an ESP in the community.

Participant H had also identified a group of patients that were referred to another hospital for treatment which she believed could be done by herself with additional training. She described her reasoning in the following way.

“Historically xxxx (removed for anonymity) patients have been sent over to xxxx because of people's connections and that doesn't make any sense at all that xxxx pay xxxx for that when we could provide the service in this hospital.”

The practitioners saw this as an extension of their role, where they could offer their services, acquire new skills in patient care and exercise some control on their career. Participant K described how she was prepared to adapt her role for a community setting.

“I do think we need to develop more out into the community. Also to an extent, it feels like a really natural extension of our current role.....”

For most of the participants the move into community would be an outreach service from the hospital based on a perceived opportunity and gap in the market. Participant B had already made a part transition into primary care working directly with GPs using the skills she had developed working with orthopaedic consultants. She was still employed by the hospital but provided an out-reach service. She described how this worked.

“There isn't really a difference between let's say the MSK clinic (a musculo-skeletal clinic in primary care staffed by General Practitioners with a Special Interest (GPSIs) and ESP) and

the orthopaedic clinic that I run..... I think because they have had to put out some work to the external sectors and they don't really want to do that so they have basically said to me they want me to continue with that clinic because they need capacity."

In other word, the symbiotic relationship between the hospital and the PCT prevented patients being referred to an alternative provider and maintained the resources and finances in the local health economy. Participant B found the transition into primary care straightforward because she was supported by the hospital and no one else was providing the service in the community. However, Participant I found the situation much more difficult because the PCT was in direct competition with the hospital as a provider of services. When asked about his working relationship with practitioners in primary care, including physiotherapists, Participant I became very animated. He went on to explain.

"It doesn't. It's a constant source of (heavy sigh) frustration and irritation to me. Because what happens is that we organise, we have the PCT musculoskeletal service that operates, with physiotherapists that operate, they operate a triage service filter system, for referrals into Orthopaedics and then within the acute trust we have an entirely separate musculoskeletal service and never the twain shall meet."

Pathways and links with primary care services, and working relationships with clinical colleagues, existed but changes in funding and the introduction of competition between providers produced some tension. He was perceived as a threat from other health care professionals (including other physiotherapists) employed to provide extended role services, supporting GPs, in the community. Participant I was clearly frustrated by being unable to initiate change.

"It is that constant sense of frustration on my part that we have the two systems that operate very separately. They don't talk to each other anywhere near sufficiently enough. And it's my view that they should dovetail into one and actually amalgamate into one service rather than

have a separate PCT service and a separate acute service. The two should just amalgamate together. The issue then is the politics of the resources etc.”

Participant I concluded that the continual change, uncertainty and frustration to bring about change had made up his mind to seek early retirement if the opportunity arose.

“I’ve had discussions with my boss about as well because I’m 52 and I can retire at 55 and my plan is that I will take early retirement.”

Participant G also felt that his ability and motivation to continue promoting his ESP role had waned. At the end of the interview he summed up the effects of change and the regret that his clinical knowledge and the role he provided would be lost. He became a little melancholy as he predicted the outcome of the hospital review of services.

“This review is potentially the most difficult one yet and whilst I don’t lose sleep over it because of got to the stage now where I’ve been through so many reviews and challenges. I’m now coming up to 37 years qualified, and I’ve been through so many changes and I have worried so many times in the past about things that have never happened. I have learnt not to do that now because it’s out of my control. It’s still there thinking I don’t know what and come out of this review and it would be on a personal level, purely a personal level it would be, it would be a shame, my clinical skills will be lost if my job goes, my clinical skills will be lost.”

In contrast, Participant C discussed moving his service out of the hospital and work directly with community teams and GPs. While the other participants discussed providing an out-reach service from the hospital Participant C discussed taking it a step further and offering his service and employment to the community services. The reason being,

“I feel that the majority of work does lie in the community, in primary care.”

When asked if this might provide a little friction between this new role and medical consultant colleagues in the hospital he acknowledged.

“Potentially (pause)...but that would have to be negotiated and discussed. But, again we have waiting lists, we have more work than we can really do. All our clinics are full to capacity so anyway if we can make the pathway smoother for the patient or delivering more care quickly, they would be happy with that.”

The lack of perceived conflict was based on Participant C belief there was a huge amount of work and setting up a new service would not alter the current relationships between clinical colleagues. However, he was unsure how this would influence the financial arrangements of the Trust if he was treating patients previously referred to the hospital.

Periods of change can trigger differing responses from actors within a field because of conflicting views and differing solutions (Battilana and D'Aunno 2010). When alternative solutions conflict actors embedded in an organisation need to reconcile and negotiate a solution that meets the objectives of the institution(s) and provides a satisfactory outcome on a personal and professional level (Smet and Jarzabkowski 2013 p1283). Most of the participants accepted that change would occur and they would be expected to do more for the same salary or the same for less salary. Although not happy with such an outcome it was acceptable if it meant maintaining or enhancing the role. For two of the participants they were at a stage where retirement was an option. These experiences of the participants to NHS changes illustrated the limitations of an individual to bring about change.

Willmott (2011) argues that institutional work is not about individuals but is about the agency ascribed to human beings through routines, reflections and ability to act which creates the change. Participant I had agency but the strength to influence those working for the PCT was weak. The PCT had established norms and values in institutional ways of work which were maintained by the actors within it, including members of the physiotherapy profession. In doing so it created robust and accepted ways of doing things which could withstand the challenges from the hospital.

This study identifies the efforts of individuals as they attempted to create and transform institutional structures within which they work and which gave them their roles, relationships and routines. It is perhaps unsurprising that the amount of effort over a prolonged period had its effect on the participants. They were passionate about the job and role they did. They believed in its value and for most they were confident that they would weather the current storm. In summarising their experience, the following three participants capture the feelings of all the participants.

“I think it's been fantastic on many levels. Having the opportunity to do it and to develop a clinical role in an area that I am passionate about. I just don't know what the future holds really.” (Participant K)

“I'm very happy in my work. We all have bad days but, generally speaking, I still find it very rewarding. I think for someone like me who had a particular area or interest that they wanted to develop and wanted to work in think it's an ideal opportunity as a physio.” (Participant A)

Participant D explain that the role was never about the money,

“I also think locally we've done quite well. I think there will always be people at every grade that will want to advance, progress and sometimes you have to make the choice as to whether you advance progress with uncertain rewards at the end of it because you want to improve personally, professionally and you hope that you will be recognised for that. If it comes to something (in terms of financial reward) then great if it doesn't it doesn't. At least you feel you're developing and that's what lifelong learning is about, isn't it?”

It is probably for this reason that the participants, although uncertain about their futures, saw the changing times as opportunities for further personal growth (even if that was making the decision to retire from the NHS). This inter-woven cycle of agency, negotiating and dealing with change created the dynamics for these physiotherapists to create and maintain new roles. The following discussion uses institutional work as a conceptual framework to gain some understanding of the participants` experiences. Viewing the experiences of the participants

through an institutional lens shows them constrained by institutional arrangements (as in clear lack of support from consultants in the examples of Participants B, F and K) but at the same time altering and modifying those constraints so that a change in role and remit can occur. Institutional entrepreneurs are defined as agents with sufficient resources, who bring about change motivated by their interests (DiMaggio,1988). By undermining the status quo or through addressing field-level problems, institutional entrepreneurs can be the driving force of new initiatives and professional developments (Maguire et al 2004). The following discussion begins by considering the participants as institutional entrepreneurs in their ESP roles before arguing that their experiences can be understood as institutional work. In doing so it adds to the published work on the experiences of ESPs and provides an insight into the processes of creating and maintaining new clinical roles using the typology of institutional work. The concept is evaluated from the “ordinary” individuals’ perspective showing that it can be applied to the various layers within an institution and to professional change. Finally, the rhetoric and work of the CSP and of the ESPs are considered as a way of looking to the future for physiotherapy. In doing so it begins to answer the aim and subsequent objectives of the study which are discussed in the next chapter.

Chapter Seven Discussion

7.1. Introduction

The participants were motivated to extend their role in clinical areas they were passionate about. Like other studies, (Dawson and Gharzi 2004, Currie et al 2010), they were driven by a love of learning, a desire to be able to do more in clinical practice and the feeling of job satisfaction. Contrary to the criticisms of Kerstein et al (2007), the participants were robust in ensuring effective and efficient safe practice. They imposed boundaries to define their scope of practice. They initiated audits to demonstrate outcomes and worked to create an infrastructure through education and the on-going support of consultant colleagues. They were aware of the pressures within the organisation in terms of cost pressures and clinical demand, and saw the opportunity to provide a solution in terms of creating a new role. The experiences of the participants demonstrated purposive action aimed at changing institutional arrangements both in terms of what physiotherapists do and the relationship they have with other actors in the field, particularly medicine.

This section considers the participants as entrepreneurs before examining the types of institutional work they were engaged in creating and maintaining the ESP role. It identified the successes and weaknesses and provides details that others might find helpful when considering ESP roles. Finally, the chapter considers the roles within the context of the physiotherapy profession and draws on other professions, particularly nursing, for comparison.

7.2. ESPs as Institutional Entrepreneurs

One view of entrepreneurship is that opportunities are discovered by entrepreneurs based on a positivist epistemology that argues that opportunities are objective realities that exist in the environment and are discovered because of the unique characteristics of individual entrepreneurs (Shane 2012). Thus, it is the individual's characteristics, experiential background, propensity to risk and cognition that permits them to identify and act on a gap in the market that is largely invisible to other actors. The experiences of the participants, within this study, points to their willingness to take risks and their ability to see the potential of an ESP role.

However, this world-view fails to account for the ways the participants moulded the role because of their work with others. To accommodate this there is an alternative position which gives more insight into this experience of creating and developing the ESP role and puts the individual participant at the heart of the process. This view point argues that entrepreneurial opportunities do not exist in an objective fashion, nor do they exist prior to the awareness of entrepreneurs. Rather, "creation opportunities are social constructions that do not exist independently of entrepreneurs' perceptions" (Alvarez and Barney 2007 p 15) and are co-created with others in the workplace. This perspective acknowledges that certain objective conditions in the environment, such as technological advances, political or regulatory shifts, contribute to entrepreneurial opportunity. However, this view argues that entrepreneurial opportunities are ultimately determined, not by the external environment, but through the creative imagination and social skill of the entrepreneur (Suddaby, Bruton and Si 2015).

Opportunities, from this point of view, extend beyond identifying and filling gaps in the market. They exist in a broader, social or cultural context that is articulated through the interaction of an entrepreneur's unique and creative perceptions and the demands of the marketplace. These entrepreneurial opportunities are therefore a product of both, creative imagination and creating the need or solving a problem that is acceptable to others. The entrepreneur must

innovate products, in this case their clinical role, which solved a problem of clinical demand and produced job satisfaction while simultaneously innovating social acceptance for this new role. This involves considerable social skills in persuading an audience of the need for the innovation (Suddaby and Greenwood 2005).

These two different world views of entrepreneurship, the discovery of opportunities and the creation of opportunities have been suggested by some authors to occur simultaneously but characterized with different degrees of agency depending on the situation (Sarasvathy 2001 Garud and Giuliani 2013). In other words, depending on the context, opportunities may exist which are then exploited by the individual while on other occasions the individual may create the opportunity and then exploit that creation to their own ends. In the former an example would be comparison websites which identified a need for the customer to compare various offers from producers in one place rather than searching each company separately. In the latter, Suddaby et al (2015) give the examples of when Steve Jobs created the iPhone, he did not see a pre-existing gap in the competitive environment or in consumer demands to fill. Rather, he recognized that he could create and promote a product that consumers did not even realize they wanted. Similarly, when Edison created the electric light bulb, he supplemented the innovation effort with a tremendous effort to legitimize the product — i.e., to socially construct the conditions for consumer acceptance of a product that had no prior contextual understanding or awareness in the marketplace

Alvarez and Barney (2012) reject the idea of combining two contradictory views of entrepreneurship, noting that they are, in fact, two different theories with alternative assumptions about the nature of the world and how we might gain knowledge of that world. This aim of this thesis is not to debate which theory is better but it does recognize the value, and the limitations, of each of these perspectives. The experiences of the participants illustrated how they created and maintained the role. In their interviews, they identified being in the right place at the right time and the established working relationship they had with consultant colleagues. This provided them the opportunity to reduce the consultants' workload

and through working together they created the role. Incrementally they added additional skills and responsibilities to establish their identity within the clinical field and maintained it through meeting clinical demands. They reinforced this position by demonstrating, through audit, their effectiveness and cost value.

Lockett et al (2012) drew on institutional entrepreneurship to analyse the dynamics of institutional change in a healthcare context focusing on the activities of one consultant. The authors identified the way the consultant identified the key professionals and then spent time building up a relationship with each of them. Using the right language, consistent with the aspirations of the other individuals or professional groups, the consultant convinced them about his sincerity in improving patient care but more importantly his role in the new arrangements. There was a careful alignment of changes to existing working practices with existing professional interests. The key to success was the way in which the consultant connected his change project to the activities and interests of other actors in ways that gave other professionals reasons to co-operate. It is not surprising, therefore, that institutional entrepreneurship is viewed as an intensely political process (Breto, Lamothe and Denis 2014). The nature of this politics was apparent in the experiences of the participants in their negotiations with consultants, managers and other healthcare professionals.

Participant F describes how politics involved keeping all sides happy and not losing the support of consultants. In discussions with hospital managers he outlined potential cost saving which would also increase his clinical role.

“I think that if you can justify any changes then that obviously helps with the management and their acceptance of a change and if they can see a financial gain.....But you don't want to push things and keep get people's backs up with regards to the medics and do things without their consent because we do work very closely within the clinics.

Participant F highlights the experiences` of the participants trying to create institutional change within the confines and restricting arrangements of already established institutions. His insight

shows the need to consider other vested interests and use this to build support. Marti and Mair (2010) and Walden et al (2015) found similar findings in larger collective studies. They identified that marginal actors proceeded cautiously and incrementally aware of the need to build support, trust and recognition.

For physiotherapists or others considering such roles there are things to consider. The participants were pro-active, confident and able to put forward a case for change. As participant B commented,

“These are not roles for shrinking violets.”

This resonates with an earlier study on Nurse Practitioners (NPs). Tye & Ross (2000) found that confidence was the characteristic most frequently mentioned as facilitating effective working. Conversely, lack of confidence was a significant cause of isolation and stress, and limiting role expansion. In physiotherapy, Kilner and Shepard (2010 p248) described ESPs having to have the attitude of a “lone ranger” and the confidence to work alone to bring about change.

The participants described having to be in the right place at the right time and willing to take risk. Perhaps more importantly there needed to be some slack in the defined physiotherapy role of the individuals that allowed them the time to pursue these opportunities. Time was needed to design a framework that addressed education and skills and someone to deliver the training. This is best summarized by Participant H when she described.

“Finding the hoops to go through and then jumping through them.”

There was, and still is, no national or regional educational framework for the ESP role. They relied on “in house training” This is discussed later in terms of the institutional work of education (p140) but the participants negotiated the training and boundaries of practice. They had to manage their expectations and setbacks when reliant on consultants for training. There were many examples of successes in which they gained the full support of the consultant. This was more likely to occur when they provided a solution to a problem which contained no threat

to the consultant position. In contrast if there was a perceived threat as in the case of Participant B and surgery the consultants refused to provide or support the training. Participant B recognised that the consultants put an absolute block on this further development which she described as a “no-no” in emphatic terms

“It was a definite no-no and I have to say that was probably a step too far for many of them.”

Or as Participant D found.

“Sometimes when we don't see eye to eye with medical colleagues about extending roles the occasionally quoted idea that there is a training program in place and this is called going to medical school, which is sort of the conversation ender really.”

If the consultants blocked the role the participants accepted these setbacks as part of the process and considered other alternatives. In doing so, they were active in creating the role and opportunities for practice. More significantly, from the experiences of the participants, there were no pre-existing realities of the role. Rather, the opportunities were generated by reflection on the possibility of new and creative social realities created and adapted by other actors in the field. There was a co-creation of the roles. The participants actively maintained the close working relationship with consultants and other staff because they would need these social networks in the future. Despite significant setbacks Participants B and F were at pains to point out the support they had received from consultants and the great working relationship they had.

“I know that they have come to respect me a lot more because they will now talk to me and discuss things with me and even support me and there have been a few issues we've of been a bit concerned and discuss things (sic). They have been very supportive.” Participant B

“Generally, as I say the working relationship is excellent and they respect the physiotherapy opinion within clinics.” Participant F

This supports Marions et al (2015 p43) assertion that opportunities develop out of the interactions and relationships of actors in key networks and “that entrepreneurial opportunities are created by the trust and cohesion embedded in the socio-emotional strength of the actors working within the field and broader networks.” Contrary to Abbots (1988) contention, that professional boundary work involves arguments or disputes over jurisdiction, the participants avoided these through negotiation and pragmatism. They lobbied and negotiated their remit with consultants. They agreed working arrangements with nursing colleagues to ensure a collegial working environment. In doing so they ensured a status quo that accommodated each profession.

Some of the participants (A, B, H and L) identified areas they had considered extending into but decided not to because the incumbents were already firmly established. They demonstrated a sensitivity to the workplace environment and the work of other. In doing so new ESPs need to consider the effort involved in creating or extending roles and the likelihood of success. They needed to be politically astute.

All the participants were aware of the prevailing management logic and could articulate their plans and roles using the language of efficiency savings and cost benefit. Many discussed business plans they had developed to press their case. This direct conversation with managers was showing benefits in terms of management discussion with consultants over cost savings and clinical demand. The participants provided a practical solution to the managers about how to meet demand and used them as an additional resource to challenge the consultant.

The emphasis of the participants was on providing safe solutions to clinical demand issues while not being perceived as a threat to the status quo. They negotiated practical solutions to workload with consultants, agreeing roles and boundaries but at the same time used the language of markets when in discussions with managers and commissioners. They adapted the rhetoric to the context. For the consultants, it was dealing with clinical demand and

reducing their workload. For the managers, it was providing a safe cost effective option to delivering targets and maintaining income for the hospital.

Negotiations were thrown into contrast when others were perceived as not playing by the same rules. Two participants, (H, I), vented frustration towards colleagues in community services who failed to engage in negotiation and pursued their own course of action. Although angered they still felt that negotiated agreements were the way forward. The key was being able to negotiate.

For others taking on the role, or for physiotherapy managers considering supporting the role, the issue of uniform and the concept of professional identity surfaced from the interviews. Those who wore a uniform were clear they were physiotherapists. They wanted to be recognised as physiotherapists by patients and others even though they had additional skills and practised in a different setting. For these participants, being an ESP combined some practice features of medicine with the fundamental aspects of physiotherapy. Their clinical practice and identity remained physiotherapy oriented.

For the non-uniform group, there was some confusion about identity. These participants discussed dealing with, and trying to resolve, the competing logics of medicine and physiotherapy. They were, in the main, isolated from the rest of physiotherapy in that their clinics were embedded in consultant clinics. They had little contact with physiotherapy during their work and had a greater affinity with the consultant clinic than physiotherapy. Bevort and Suddaby (2015) found that successful adoption of a new logic requires a clear future-oriented or prospective subjective identification with a new role. For the participants, there was no clear future-oriented logic. They were in the process of creating their own. Hammond et al (2016) interviewed senior experienced physiotherapists in the UK about how they viewed their professional identity and concluded that it varied over time (in terms of years) and the role they were doing at that time. Physiotherapy identity was fluid across time and place, co-constructed within changing communities of practice mediated in the workplace.

Announced after completion of this study the CSP, in a new policy initiative, called for the rescinding of the title Extended Scope Practitioner in favour of Advanced Physiotherapy Practitioner to re-establish a new career pathway that includes extending clinical boundaries (CSP 2016). The importance of title given to roles is discussed in the institutional work of identity in the next section and the role of the CSP in the subsequent section (p156). However, the results of this study confirm that some participants felt they were different from “ordinary” physiotherapists and wanted recognition. It may be that with the creation of new clinical titles within physiotherapy that recognition of these roles may provide the forward-looking career pathway that makes combining medical and physiotherapy logics more comfortable. It might address the reflections of Participant I.

“I’m not the, I know it sounds awful doesn’t it, a run of the mill physiotherapist. I’m not a normal physiotherapist, I’m a clinical specialist and consider myself towards the top of the tree really and yes I want to convey that to an extent”

Lockett et al (2012) described entrepreneurs as actors who seek to initiate and enact institutional change. The participants in this study brought about change in their clinical role due to change in the working practices in the hospital; change in the relationships with other health care professionals and change within their profession. Breton et al (2014) argue that a key to success is the way in which institutional entrepreneurs connect their change project to the activities and interests of others in the field in ways that give other social groups reasons to co-operate.

Battilana and D’Aunno (2010) identified that entrepreneurship can be stimulated and encouraged at the local or field level by a jolt or crisis that needs to be resolved. This could be because of changes in regulation, new technology or new competition entering the workplace. McDonnal et al (2015) argues that the implementation of the European Working Time Directive (Directive 2003/88/EC) was the significant jolt. The participants saw the opportunity and were in a position, and more importantly a mind-set, to act. What is clear is the participants lobbied the consultants for support in changing their roles. In some cases, this support was readily

forthcoming (Participants B, C and D) but for others it was a more protracted process (Participants F, H and K) demonstrating the need for tenacity and resilience. All the participants identified the need for consultant support in establishing their role and an awareness of a need to accommodate the consultants' perspective.

Before considering the activity of the participants as institutional work (p133), one other feature in the development of the role and entrepreneurial spirit is clear in the interviews and in the transcripts. The participants were totally immersed in the role. Although they could reflect rationally on ways and means of success, and deal with setbacks, the roles were personal and part of their development. In dealing with change and adaption for many of the participants there was some emotion as they spoke. Part of this reason can be summarised by Participant E:

"I've developed the role so it's a real mixture of me individually, and I don't think I could be separated from it."

For those individuals engaged in entrepreneurial activity there was a personal commitment which lays the trail for others to follow. This commitment was more than creating a role, for the participants it was linked to them as individuals. This is unlikely to be the case when practitioners step into established roles. So, for those physiotherapists engaged in extending professional boundaries and roles, it is a significant personal endeavour without, it appears, the support of the profession. The participants recognized specific situations and chose appropriate behaviours with some planning for future change and an emphasis on getting the job done. Like the findings of Smets and Jarzabkowski (2013) the ESPs were engaged in the mundane work of institutions without necessarily being intentional in the narrow sense of institutional work as 'purposive action aimed at creating, maintaining, and disrupting institutions' (Lawrence and Suddaby, 2006 p 217), but in the broader sense of accomplishing their practical work and reconstructing parts of the current institutional order.

The following section considers the activities of the participants as institutional work using the taxonomy developed by Lawrence and Suddaby (2006). The experiences of the participants, creating and maintaining these roles, can be understood within an institutional context. The successes and weaknesses of the various types of institutional work are considered which provides insight into the possible reasons for the outcomes. In addition, taking this approach adds to the development of the institutional work concept by providing lived examples of individuals engaged in changing institutional arrangements. It addresses the issue of putting the individual back into institutional work (Suddaby 2010, Lawrence et al 2011) and adds to the nuances and tuning of the taxonomy of the concept (Currie et al 2012).

7.3. The Participants' Experiences as Institutional Work

7.3.1. Introduction

While the taxonomy defines types of work specific to creating, defining or disrupting institutions the experiences of the participants suggest that different types of institutional work interact and mutually support each other. The participants were not in a position of power or in control of resources and so can be considered as marginal actors (Marti and Mair 2010).

Smit et al (2012) argue that creation work is only possible when dominant actors (in this case the consultants) and frameworks are involved in the relationship. Marginal actors are often a source of novel ideas because of a drive for improvement in status (Waldon et al 2015). In contrast, privileged actors are 'unlikely to come up with novel ideas or to pursue change, because they are deeply embedded in, and advantaged by, existing institutions' (Hardy & Maguire, 2008, p. 199). However, change does occur when a relationship develops between dominant actors and marginal actors based on common understanding and consensus (Topal 2015). This, it is argued, occurred in the experiences of the participants.

This section is divided into three sub-sections. The first examines the types of institutional work that appear to have brought success to the participants and their role. The second

examines the less successful aspects of institutional work and why that may be the case. Like Currie et al (2012) the different types of institutional work blended at times. In that, there were times when creating new parts to the role using aspects of maintenance work and maintaining the role used features of creation work. Some types of work were not clearly identified and these are examined in the final section when the interface between the institutional work of the participants and the CSP are considered.

7.3.2. Successful Types of Institutional Work

Perhaps the most successful type of institutional work which helped create the roles was the work of mimicry and the way the participants set out to mirror the thinking and clinical practice of the consultants they were working alongside. Lawrence and Suddaby (2006 p225) argue that part of the success of mimicry is the “juxtaposing of old and new templates can simultaneously make the new structure understandable and accessible while pointing to potential problems or shortcomings with past practices.” In creating the roles, within the already established consultant clinics, the participants created something that was recognisable and acceptable to patients and consultants. It also provided the opportunity to demonstrate to hospital managers (and the wider health service through advocacy by the CSP) the efficient, effective and economical use of ESPs to meet health care needs. Creating a role which could deliver part of the consultants’ workload in the same manner was the first step in establishing the posts.

The participants spent considerable time working with the consultants. In their interviews, they talked about learning to think like their consultant in the clinical situation. In doing so the participants assimilated a small part of the consultants’ way of assessing patients as Participant I explained.

“Working alongside the consultants definitely helps because I think you're getting that cross pollination all of the time with them so that knowing what they will operate on, won't operate

on, you know the types of procedures that are there. What to investigate and what not to investigate.”

In doing so the consultants fostered a dependence on their role and maintained their own position within the organisation (Currie et al 2012). It could be argued that the work of mimicry minimised risk to patients by creating practitioners who followed consultants' guidelines. From the practitioners' perspective, it provided a starting point for developing the role and maintained the working relationship with the consultants. The participants were comfortable with these arrangements in that it enabled the role to become established in the institutional field from which it could then develop. Like the findings of Kroezen et al (2015), the participants compromised their expectations of the role to become competent and maintain the support of the consultant.

Once established in the institutional field through the work of mimicry the participants began to engage in the work of changing normative associations. This involved the construction of inter-organizational connections through which practices became normatively sanctioned. The participants presented clinical audits to consultants highlighting the successful outcomes of their interventions and the number of patients they could assess and discharge. These audits served two functions. First it reassured the consultants about the safety and effectiveness of the roles. In doing so it showed them able to take on clinical work previously only undertaken by consultants. More importantly it provided the evidence to secure their position within the field. Secondly the evidence from the audits was used by the participants within the management framework of the hospital to press for recognition. They presented themselves to managers as an alternative to a consultant.

Changing normative associations was linked with two other forms of institutional work. Firstly, enabling work in which, through negotiation, working models and boundaries were agreed to prevent conflict. Secondly, policing work, (through enforcement, auditing and monitoring), this ensured that agreements and quality was maintained. Both types of work in the taxonomy are

associated with maintaining an institution but in the experiences of the participants they were used to both maintain and create the ESP role.

In terms of being enabled the participants described how they set up the service, the type of referrals they would accept or decline and the limits of their service based on their competencies. They were very clear on their extended practice boundaries. If these rules were breached, as in the case of Participant J, when a different clinical caseload was assigned to her by the hospital manager to meet a hospital target, the participant refused to accept the referrals based on competency and patient safety.

The participants voluntarily and robustly policed their practice through audits, publishing clinical outcomes and service data. A standard technique of demonstrating the effectiveness of a new service or to raise the profile of a role in order to gain recognition or additional funding, is by publishing audit and outcome data (Kerstein et al 2007, Stanhope et al 2012). The participants did this but they also collected the data for two other reasons. The first, although not encountered by the participants, was having clinical outcome data available that could be used, if needed, to counter any potential demonological work of another profession (see description p198-199). Secondly, by going above and beyond what was expected the participants maintained control. The participants created the relationship and framework with the dominant actors.

Currie et al (2012) identified that one of the ways consultants in healthcare maintain their position was by imposing structure and monitoring on other professional groups to the task they have delegated. In contrast, there is no evidence from the participants that this was the case. By consciously imposing rules on their own practice based on competency and self-policing they established a degree of independence and autonomy in the role and trust from the consultants in delivering the service. Evidence from the participants show they were acutely aware of the innovative nature of the role for the profession and the impact serious errors or mistakes would have on the perception of ESPs. Repeating the quote from Participant D reflects why they were robust in establishing rules and policing them.

“I think that most people that go into senior clinical roles and are pioneering the extended role approach are extremely well motivated, have high professional standards and are very aware that they are not just shouldering their own professional development but also the professions. That if you make a cock up it probably sets the development of something like that, in the same area, back five or ten years.”

Establishing this framework and overtly policing it enabled the participants to embed the role into the organisation and over time their practice became ordinary day to day routines. The original innovative practice, seen in the creation of the role, lost its newness and blended in with the normal practice of the clinical area. It may be that one of the features of maintaining success is when the practice of a profession is accepted as a feature of an institutional field without anyone noticing or commenting on it.

The ESP roles ran parallel with existing institutions (the consultants) and provided a degree of comparison. Further, in conversation with the participants they incorporated within their role an association with a new business model. They were keen to describe how their discussions in redesigning patients` services emphasised their practices with efficiencies and value for money. All the participants discussed the gradual increase in recognition for the role brought about by working with consultants; arguing the benefits of the role and producing the evidence. Hargreaves and Van De Ven (2010) contend that effective institutional strategy is predicated on a careful reading of other actors` interests and expected moves. Individuals` identities are in part defined on the perception of others and benefit by managing their opponents` perception of them. The participants actively created a perception of their role which was productive and solved the problem of increased clinical demand. They defined the role, boundaries and rules of the new institutional structure and practice. This was still work in progress and there was no evidence from the participants that they had achieved the final stage of vesting in which these new rules confer rights on the new institution.

There is nothing in the participants` transcripts of a strategic direction or endpoint for their roles. Equally the changes in role were not accidental or unintentional. In conventional

institutional change, entrepreneurs first define a project and then "bargain for support and acceptance from external constituencies" (Dorado 2005 p389). In contrast, the participants were focused in the situation and consequently, the role changes were not motivated and coordinated by institutional strategizing for the future, but by the common purpose of "getting the job done" (Smets, Morris, and Greenwood 2012 p896). The impact of this was that the process of change was non-linear, as localized adaptations were conceived and tried. The institutional work of changing normative associations was related to participants' solving a problem. It focused on the justification of a solution, rather than the framing of a problem, and was aimed at persuading a narrow practitioner community within the speciality clinics, rather than a variety of audiences, of the pragmatic benefits of change. This would explain the individual nature of each development and the lack of succession planning. The change in normative association related to the individual and not the profession. This is an important implication, which is discussed later in the macro context and the role of the CSP, but if change is only associated with the individual and not with the wider profession then it cannot be sustainable.

Lawrence and Suddaby (2006) concede that most types of institutional work aimed at disrupting institutions involve the state or state sponsored bodies. "Disconnecting sanctions" and "disconnecting moral foundations" of an institution involves wholesale change at the macro level. In contrast, aspects of the third type of work "undermining assumptions and beliefs" could be identified at the micro level in the way the participants worked to create original solutions to a clinical demand. The creation and maintenance of the role had an impact on the way the role of the consultant was perceived and the type of clinical work that could be undertaken by the ESPs.

Lawrence and Suddaby (2006) state that for institutions to be disrupted key actors must undermine core assumptions and beliefs about the risks and costs associated with innovation and differentiation. They argue that this work is typically done by a marginal rather than a powerful actor who is 'capable of working in a highly original and potentially counter-cultural

way' (p. 238). Prior to the establishment of ESPs, the clinical work was undertaken by consultants, or junior doctors supervised by consultants, in out-patient clinics. The act of undermining assumptions therefore begins with the 'counter-cultural' act of recruiting the ESPs to undertake some of this work.

Lawrence and Suddaby (2006) refer to actors undermining assumptions and in this study institutional work the actors include: the consultant (as the embedded actor), the ESP (as the catalyst) and the hospital manager, patients and other professionals (as the external actors). Each contributed to the change and the experiences of the participants. The consultant by accepting and supporting the role while maintaining their own position. The hospital managers by recognising the role as an alternative and proposing change in staffing arrangements. Other professions through agreeing boundaries and patients by accepting the ESPs as an alternative to a consultant outpatient appointment. As Hargreaves and Van der Ven (2010) argue, the institutional work of actors is dynamic and interactive as they read the interests, strategic moves and counter moves of each other.

It is clear from their interviews that the impact of the change created and maintained by the participants was not fully recognized. Partly this is due to the amount of time needed to bring about change and secondly to appreciate the level of change there is a need to take a broader view. The participants were living the experience and during the interviews they reflected on where the journey began, how much change they had achieved and how long it had taken. The work of the participants was localised to various hospital departments and to a certain extent hidden from view. It is only when the whole scale changes achieved by the participants are considered that the impact of disruption can be considered. This is exemplified by the CSP using case examples of change (such as physiotherapy/orthopaedic triage service with same day diagnostics and assessment; independent prescribing rights and physiotherapy practitioners providing first contact care in GP practices) to further consolidate the changes and advocate for more (CSP 2012, 2014). The CSP has produced a number of promotional leaflets for GPs based on practice innovation and the effectiveness of physiotherapy and

publicises the effectiveness of physiotherapist in GP surgeries (CSP 2016). It also continues to lobby through press releases for patients to have direct access to physiotherapy (CSP 2017) referring to evidence collected by its members

It has been argued that institutions are kept in place by the costs and risks associated with moving away from taken for granted practices (Hargreaves and Van de Ven 2010, Currie et al 2012). The experiences of the participants show how these costs and risks were minimised in several ways. Firstly, the individuals were all known to the consultants and had a developed professional relationship over many years. There was a level of mutual respect and trust between the consultants and the participants which minimised risk. Secondly the consultants recognized that the ESPs could free up their time and meet the pressures of clinical demand. Third, from a management perspective, the participants could deliver cost savings and meet demand. Finally, there was an acceptance (or no resistance to the change in role) from other healthcare professions, particularly nurses, and more importantly the patients. Rather than disruption the changes could be considered as re-alignment as the professions responded to institutional change.

7.3.3. Less Successful Types of Institutional Work

Lawrence and Suddaby (2006) argue that education is more than the acquisition of skills and knowledge; it provides the template and structure that others can follow. All the participants had completed post-graduate university courses in their area of specialism. However, the initial development of the ESP role depended on either in-house training or the practical component of academic courses had to be delivered and assessed by a consultant. For example, participants with injection skills completed a post-graduate university course in the theory of practice and pharmacology but the qualification depended on the practical component in the workplace supervised by a consultant who was responsible for certifying competence. Post graduate courses for extending roles, delivered and assessed by physiotherapists for physiotherapists and recognised by hospitals and the NHS appear not to

be readily available. This is not unique to physiotherapy. Nursing has had advanced practitioners in many countries for more than thirty years but education and its link to practice within the organisation can still be problematic.

Carlisle (2003) argued that for the full potential of the nurse practitioner role to be achieved, changes were required in traditional organisational structures for nurse-led services to be feasible and acceptable to all stakeholders. This would require strategic planning for the education of practitioners but also a framework and commitment within the organisation to enable the practitioners to apply this new knowledge and skills. In this way, new nursing roles, such as the nurse practitioner, are more likely to be truly advanced and not simply developed by taking on of a new skill previously the province of another health care professional. Heale and Buckley (2015), in a recent review of advanced nursing from an international perspective, found that, even with recognised qualifications in advanced practice, barriers and opposition to the roles came from physicians, medical organisations, pharmacists and administrators within organisations. Ryley and Middleton (2016), from a UK perspective, found a lack of clarity around the educational preparation required to work safely and effectively at a level above that of initial nurse registration and concluded that this has caused confusion for the public and debate among health professionals about the scope and competence required by advanced practitioners.

Jones et al (2015) argue, for advanced nursing roles to flourish there is the need for development opportunities, support and integrated working needed between professional representatives, managers, commissioners and educators to deliver sustainable service delivery. The same sentiment applies to physiotherapy. Skinner et al (2015), examining physiotherapy post graduate education, argue for the need for formalised, widely recognised training to support these roles, and found significant challenges to the delivery of such training. Many of these roles function in the absence of specially defined standards of clinical practice and it is unclear where the responsibility for training provision lies. Therefore, dependence on in-house training in the UK for ESPs will remain (Mir et al 2016).

However, in the Australian state of Victoria, a competency based educational programme for ESPs has been developed. Harding et al (2015) describe the essential programme as a Masters qualification and argue that any in-house education should focus on the gaps not addressed in the Masters course. In-house training should not be considered as a replacement for post graduate university qualifications. This is consistent with the nurse practitioners in Australia and New Zealand (Heale and Buckley 2015). All the key components required for implementing a competency-based training and assessment program have been developed to provide clarity and transparency for the physiotherapists and stakeholders. In addition, the physiotherapists in the project used the evidence of successful competency attainment to support transferability of their roles between health services, thus increasing workforce capability and sustainability. There is a time delay in innovative clinical practice and the provision of clinical study programmes especially when there is no strategic direction for where physiotherapy practice is destined.

The experience of the participants highlights the individual nature of their role creation but also the lack of an engagement with a professional network to support and maintain change. A professional network of ESPs exists but membership is voluntary. None of the participants referred to this professional network. Lawrence and Suddaby (2006; 221) outline a requirement to construct a normative network which they describe as “inter-organisational connections through which practices become normatively sanctioned and which form the relative peer group with respect to compliance, monitoring and evaluation.” Or as Hwang and Powell (2005 p188) describe, entrepreneurs need to juggle the “dual roles of creation and enforcer”. This can be seen in the individual experiences of the participants in the robust ways they policed themselves through audit and published data within their hospitals but sustainability and maintenance of such roles needs to move from the individual to the collective.

Labelle and Rouleau (2016) showed how individual hospital risk managers in Canada enhanced their professional profile through creating a voluntary real and virtual network.

Networking with colleagues included formal and informal gatherings quality, performance, and risk management practices were debated. This networking was an important way of integrating newcomers. Labelle and Rouleau (2016) argue that pro-actively setting the agenda, the collective of risk managers within the region shared their everyday experience and built a common professional discourse. Increasing the density of their network, risk managers reinforced the institutionalization of risk management at the local level and their strength as a professional collective seeking recognition. By identifying best practices, discussing the best ways to implement them or sharing innovative practices with other risk managers could generate, diffuse, and apply knowledge within their own workplace. The whole, or collective group, became greater than the individuals and in doing so they began to address the shape of their professional identity through social interactions with peers. However, despite this there was no agreement on the future orientation of the profession. The risk managers blamed this on a lack of political will to provide an official description of their role and duties, along with professional jurisdiction. Rather than letting this stifle change, Labelle and Rouleau (2016) found that the risk managers in individual hospitals took advantage of the ambiguities to experiment with what a future role might look like. Like the ESPs, there was a degree of freedom to engage in an evolutionary process.

Ibarra (1999 p765) describes a phenomenon of creating 'provisional selves' as "temporary solutions people use to bridge the gap between their current capacities and self-conceptions and the representations they hold about what attitudes and behaviour expected in the new role." In other words, creating a role that is somewhere between what an individual was and where they want to ultimately become. The same can apply to collectives and professions as they develop. In institutional terms, Lawrence et al (2002) argue that one step in creating an institution is to develop a proto-institution. In other words, creating a recognizable entity which embraces a collection of individuals engaged in the same or similar practices. In doing so, these new practices, rules or technologies can be explored within a recognizable framework. If successful there may be a diffusion of these changes and an acceptance of the outcome as

the solution to a problem. Di Maggio (1988 p14) in his seminal paper stated that “new institutions arise when organized actors with sufficient resources see in them an opportunity to realize interests that they value highly.” Elaborating on this Marti and Mair (2010) contend that there are stages in this process, or provisional institutions, that serve the actors interests for a period of time and will either develop and flourish or wither and decline over a period of time based on the agency of the actors and the context in which they operate.

These proto-institution can then take on the mantle of an institution but Battilana and D’Aunno (2009) argue the actors must engage in work aimed at imagining and theorizing the future role. This has links to the institutional work of identity and theorizing. From the experiences of the participants this is work in progress which could be addressed by a more robust professional network and greater support from the CSP.

Lawrence and Suddaby (2006 pg221) define the institutional work of creating an identity as “defining the relationship between an actor and the field in which the actor operates”. For most of the participants being an ESP was secondary to their identity of being a physiotherapist. However, for a small minority there was uncertainty about their professional identity. This is important because professional identity plays a central role in making sense of the working environment and careers (Weick, 1995).

Pratt, Rockmann and Kaufman (2006), argue that identity work is a nuanced and dynamic process of social construction that requires individuals to navigate competing institutional pressures. It involves experimenting and adapting provisional identities until a collective view and agreement is accepted. This could provide an explanation of the experience of participants who felt confused about their role. Working almost exclusively in a medically orientated environment and practising outside of conventional physiotherapy they adopted a provisional identity of “other”. In that, they were not medical practitioners but felt different to physiotherapy so they therefore felt unsure of their role.

Everitt (2012, 2013) points to sense-making and identity as key elements of understanding how individuals subjectively interpret, enact and creatively reproduce institutions. Blomgren and Waks (2015) observed that to make sense of institutional complexity, individual professionals confronted with multiple logics may become 'hybrid professionals' as a way of subjectively coping with oppositional logics. Suddaby et al (2015) extended the concept of hybrid professionalism by showing how actors' sense-making and identity work can successfully integrate organizational values into one's professional identity thereby successfully integrating both managerialism and professionalism into a coherent sense of self. It could be argued that the ESPs incorporated the CSP's professional project of extending the roles of physiotherapists, meeting the clinical demands of the organization and achieving their own personal goals. The sacrifice for some was the temporary ambiguity about the professional roles they were undertaking.

Drawing on the literature on advanced nursing roles allows the development of the ESP role to be seen in context. Lowe et al (2012) in a review of international arrangements of Advanced Nurse Practitioners (ANPs) found that in Singapore, there is no Nurse Practitioner (NP) regulation, but there is an advanced practice accreditation. In Australia and New Zealand, there is no advanced practice accreditation, but there is NP accreditation. In the UK, the title of NP or ANP is not protected, or under any regulatory governance, unlike the role in other countries such as Australia, Canada, Ireland and the US. This lack of organizational understanding of an advanced practice nursing role led to wide variations in practice, lack of role clarity, inconsistent expectations, restrictive employer job descriptions, and variable stakeholder acceptance (Llyod-Jones et al 2005; Altersved et al 2011; Lowe et al 2012; Heale and Buckley 2015). Physiotherapy has mirrored some of these frustrations but recent changes in CSP policy have produced a new framework for careers and roles with the advocacy of advanced practice physiotherapy (APP) and Consultant physiotherapist roles (CSP 2016). These are discussed in the next section (p150), when considering the work of the CSP. The creation of these defined job titles goes some way to addressing the issues of identity and

career progression within the physiotherapy profession. More importantly it highlights the need for integration of institutional work between the individual, the profession and the wider institutional arrangements of the NHS. Change, lack of direction and overarching structure created a sense of professional confusion in some of the participants.

This ambiguity in identity is linked to a weakness in the institutional work of theorizing which is part of the process of maintaining institutional change. Lawrence and Suddaby (2006) argue that an important aspect of theorizing is the naming of new concepts and practices so that they are recognized as part of a field. It has been argued earlier that the participants changed the normative associations of the physiotherapists' role within the hospital by their practical abilities to perform the role usually associated with consultants. However, Greenwood, Suddaby and Hinings (2002) contend that constructing normative associations is not theorization by which existing arrangements and practices are disassociated from their moral foundation and by which situated improvisations are justified. Theorizing refers to the creation of abstract categories to diffuse new practices that can support new institutions.

To put it simply, the participants were accepted in the role they performed and this changed the relationship and normative associations about who could perform the tasks usually associated with a consultant within that hospital or department. However, the bigger step of having the role, skills and responsibilities associated with the physiotherapy profession had not been completed. The participants explained that if they left the posts may not be filled and there was no assumption that the posts would be filled by a physiotherapist. The link between the role and physiotherapy was not firmly established.

Localized experimentation can become a base for theorizing through the transition from individual practices to an organizational and institutional level construct. It involves the definition of the situation requiring intervention, as well as specification of the intervention and its rationale (Greenwood et al 2002). It is in the process of theorization that local deviations are abstracted, modified and generalized solutions proposed. Theorization enables the diffusion of the newly proposed initiative beyond its initial context (Szkudlarek and Romani

2016). In other words, the work of the participants must be used as evidence of best practice on the national scale and advocated by the CSP as a role for physiotherapists and, more importantly, a role that is incorporated within the physiotherapy profession. Defining the role within physiotherapy and accumulating the experiences of practitioners enables more standardized arrangements to come into focus. The concept of the role moves beyond the organisation and into the wider domain of health care and the institutional arrangements of the NHS. At this point the construct of what the ESP in the NHS can be defined independent to the hospital, or organisational arrangements, and becomes available to other hospitals and clinics.

Hardy & Maguire, (2008) suggest that practice-driven changes can become embedded without the loud appeal or use of rhetoric by disaffected actors seeking to mobilize support for change. As Abbot (1988) suggests, the pressure of getting work done means that professional boundaries cannot be strictly maintained. The inter-professional division of labour becomes an intra organisational one which is established through negotiation and agreement within the workplace. In other words, the demand to meet clinical demand means that professions come to agreements about sharing the work load and this means that professional boundaries become blurred. This happens incrementally over time without a strategic end-point. It occurs with the aim of solving workplace problems, in most cases meeting clinical demand with existing resources. Once seen to be effective in solving the problem it becomes accepted within that clinic or organisation as normal practice sometimes to the point that it is not view as an innovation.

The implication, paradoxically, is that the highly localized, pragmatic improvisations of practice driven change may be harder to resist than the more visible actions of identifiable institutional entrepreneurs, especially those that involve rule-based changes such as new laws. This is because the workplace solutions avoid the attention of regulators and potential resistors until they have become relatively pervasive well established and proved to be effective and safe (Lawrence et al., 2002).

The experiences of the participants describe practice-driven improvisations occurring under the regulatory radar, developing in a loosely coordinated manner without attracting attention. This, low visibility and unobtrusiveness embedding at the field level creates favourable conditions for further improvisations. Positive feedback from consultants, managers and patients amplified small improvisations and reinforced their legitimization. These sets of practices and symbolic constructions create a logic (Helfon and Sydow 2013) which was then used by the CSP to create a social movement and theory relating to the efficiencies and effectiveness of having ESPs.

This theoretical component if linked with education could form a template to provide the profession, organisations and their members with a vocabulary, values, beliefs, rules and a sense of identity. The work and experiences of the individuals could be used to develop a profession wide change through institutional work of the CSP. This is discussed later when considering the interface between the macro and micro nature of institutional work but it is an opportunity to integrate the different institutional work-streams of the individual and profession.

Another form of institutional work linked with maintaining new institutions is valorising and demonising. Lawrence and Suddaby (2006) describe the former as work that reinforces the positive aspects and benefits of the institution, which could include how safe it is, how effective it is and what it has contributed to society. The latter, in contrast, is work that focuses negative attention on other parties who threaten or challenge the institution by pointing out their weaknesses or inefficiencies. The two strands together are used to create uncertainty and concern in an alternative institution while emphasising all the positive qualities in the current or new arrangements. The participants were keen and able to point out the successes of the roles in terms of clinical outcomes, safety and cost effectiveness. In conversation with hospital managers and commissioners they emphasised their effectiveness but more importantly the cost efficiencies of their role when compared with consultants. However, they realised that the work of demonizing would be counter- productive. They needed the support of consultants and other professions to continue their developments.

Although there is no evidence that consultants used the risk to patient safety as an argument against creating ESP posts, the participants were aware that this could happen. They were also aware of consultants negotiating for more medical hours to meet demand (as in the case of Participant J in rheumatology and Participant F in paediatrics). More concerning for the participants was the workforce plans being discussed within the hospitals. Nurses would be competing for their roles. They were on a lower pay band in the hospitals and could use the same argument of being equally effective and more cost efficient than ESPs. Therefore, much of the maintenance work involved negotiated settlements with other actors within the field, highlighting ESP effectiveness but avoiding demonising others to avoid conflict. As discussed earlier the participants were aware of the political aspects of negotiation and sensitive to the aspirations and concerns of other individuals and health-care professions.

Lawrence and Suddaby (2006 p219) argue that the study of institutional work should be orientated around three key elements. The first highlights the "skills and reflexivity of individual and collective actors". The second provides an "understanding of institutions as constituted in the more or less conscious actions by individuals" and a third that captures an approach to action which accepts that "even action which is aimed at changing institutional order of an organizational field occurs within a set of institutionalized rules". The experience of the participants illustrates their conscious decision making and reflections on change and the acknowledgement that changing professional roles occurs within a wider institutional context influenced by agenda of others.

Lawrence and Suddaby (2006) define advocacy as, mobilizing support for the creation of a new institution. In this study advocacy took on a dual role of creating a new institution while disrupting an existing one. The participants in their conversations with managers advocated their role but this came at the expense of disrupting the established arrangements of consultant run clinics. Instead of medically run clinics they also contained ESPs and in some, there were only ESPs treating patients originally referred to a consultant. Advocacy has traditionally focused on mobilizing political and regulatory support at the macro level but the

participants used the same form of work to enable internal change rather than regulatory change.

In contrast, at the macro level advocacy is being used by the CSP to diffuse these practices and roles throughout the NHS. As highlighted in the introduction the CSP and the participants were engaged in a similar project of extending the clinical roles of physiotherapists. It therefore seems appropriate to consider how the work of the CSP and the endeavors of the participants complement or conflict with each other. The following sections illustrates how the concepts of institutional work can provide a common framework and language to examine the endeavors of the individual and the professional body and how they can complement each other.

7.3.4. Interface between the Institutional Work of the Individual and the Role of the CSP

This is a relatively short section as the focus of the study is on the experiences of the participants. However, the participants as physiotherapists were part of a profession, or institution, which they influenced and which in turn had an influence on them. The first issue, like the one of creating an education framework, is the temporal delay between the institutional work of the individuals and the profession. The participants were engaged in creating and maintaining their ESP role (on average ten years) many years before the CSP published its vision for the future (CSP 2010). It meant that the CSP could use the evidence (from physiotherapists like the participants) to lobby and advocate more ESP roles with the Department of Health (CSP 2014) as a solution to healthcare demand and the institutional work of the individual was crafted into the institutional work of the profession.

Lawrence and Suddaby (2006) argue that the different forms of institutional work are more suited to either the macro or micro context. Work that focuses on rules and establishing rewards and sanctions that enforce these rules (vesting, defining and advocacy) have a greater potential to construct new institutions on the macro scale. This is because to achieve change directly relates to the actor's position in terms of their political and economic status in

society and their ability to mobilise the resources needed for change. An example is the way the CSP achieved prescribing rights for physiotherapists through mobilising political and regulatory support (Advocacy), constructing the rule system for prescribing and the standards expected (Defining) and then confirming the right to prescribe medicines, within a framework, to those physiotherapists certified to prescribe (Vesting).

However, despite this national framework its local implementation, or micro context, was modified by the institutional work of actors within the field, in particular the consultants, as illustrated by the three supplementary prescribers in the study. Two of them Participants C and D negotiated a distinct role themselves within clinics. Participant C nonchalantly described that after a constructive discussion with the consultants,

“We came up with a set of recommendations and guidelines.”

Participant D had agreed his new role, reviewing patients` medications, with the consultant before taking the course. This allowed the consultants to see additional new referrals and Participant D to have a discrete clinic. In contrast, Participant K had no agreed structure in place and found it difficult to practice as a supplementary prescriber,

“Because there are doctors here all the time.”

Without an agreed framework and a defined clinical area to practise she was unable to act as a supplementary prescriber despite the qualification.

Krozen et al (2014) in the Netherlands and Altersved et al (2011) in Sweden reported similar findings with independent nurse prescribing. Despite a national framework, and support from the profession, implementation was moderated at the local level. The nurses negotiated a prescribing role within an agreed framework with the consultants which guaranteed the consultants` support. In doing so the nurses argued it was a first step that could be extended later but in the meantime, it allowed their roles to become established. Kennedy et al (2016), in a study of Advanced Nurse Practitioners (ANPs) in palliative care in the UK, found that ANPs came to an understanding with medical staff. The ANPs accepted limits to their roles

and an undertaking to seek guidance from medical staff for situations outside of the agreed parameters. In doing so a trusting relationship was fostered between the professions which allowed the AHP role to develop but also maintained the status quo with the medical profession.

These studies, and the experiences of the participants, illustrate the importance of the individual in both defining and developing practice which can be advocated on the national stage and implementing professional initiatives in the workplace. ESPs provided the CSP with real life examples of practice to lobby government to support and fund further roles as a safe and cost-effective means of meeting demand (CSP 2010, 2014). As an example, the CSP has successfully argued that better use of physiotherapists could be achieved by extending the role with independent prescribing rights (CSP 2013, 2014). This was achieved by the physiotherapy profession in 2014. Physiotherapists may now prescribe any licensed medication within national and local guidelines for any condition within their area of expertise and competence within the overarching framework of human movement, performance and function following appropriate training (DH 2014). The impact of this new right has yet to be established but the experiences of NPs suggests that there will be variation in local implementation and interpretation and the CSP could influence this through its work of advocacy and defining the expected roles and working with ESPs in its implementation.

The experiences of the participants confirmed Lawrence and Suddaby's (2006) suggestion that advocacy, vesting and defining are more directly related to the actor's position in terms of their political and economic status in society and their ability to mobilise the resources needed for change. Individuals contributed to this process by providing the evidence of change and its impact. This was then used by the profession to lobby the state. In recognising this relationship there is the need for the individual and profession to have the same agenda so that one supports the other. In this symbiotic arrangement, the creation work of the participants was legitimized by the CSP. In doing so the CSP maintains its own position and the legitimacy of the institutional arrangements by being the guardians of the physiotherapy profession and the

body engaged in advocacy, vesting and defining new roles based on the creation work of its members.

The CSP has more recently begun to address the issue of identity by acknowledging that the terms 'extended scope of practice' and 'extended scope practitioner' have caused confusion. In their policy document "Advanced Practice in Physiotherapy" the CSP argues that the career pathway for physiotherapists should move from graduate to Advanced Practice Physiotherapist and finally to Consultant Physiotherapist (CSP 2016). Advanced Practice Physiotherapists (APPs) would have the skills to address complex decision-making processes and manage risk in unpredictable contexts. Physiotherapists incorporating advanced practice would have completed an advanced programme of studies and be able to demonstrate the ability to work at Master's level of practice. Consultant physiotherapists would practice within complex, unpredictable and normally specialised contexts, demanding innovative work which may involve extending the current limits of knowledge (CSP 2016 p7).

Other professions have put forward similar arguments. Ryley and Middleton (2016) put forward the need for an advanced nursing framework for Wales arguing that advanced practice should be viewed as a level of practice and not as a role. These roles need to be underpinned by robust governance arrangements and included in workforce planning so that advanced practice forms part of the future in delivering flexible, affordable, safe, high quality patient care. It would provide a clear career development structure for nursing and could amalgamate the current different titles of "Nurse Practitioner" and "Clinical Nurse Specialist" in to "Advanced Nurse Practitioner".

Snaith (2016 p28) in terms of radiographers goes further. Advanced practitioners are "autonomous in clinical practice, define the scope of practice of others and continually develop clinical practice in a defined field." They deliver patient care, particularly undertaking roles previously done by radiologists such as reporting and procedures. These are then embedded within the scope of practice and become routine within the Society of Radiographers with a career pathway and educational framework. Importantly, and building on the institutional work

of education, these advanced practitioners would also provide the education and mentorship to radiographers. Consultant practitioners, she argues, provide the leadership within the specialism, innovation, research and contribute to the academic programme as experts in the field. In arguing for a restructuring of radiographers' careers extended roles and innovation are incorporated into advanced practitioners identified within radiography. There is no ambiguity about identity.

The work of individuals is being consolidated at the national level and put forward as a professional agenda but there are some significant issues to address. The CSP is at pains to point out that roles develop in response to local healthcare needs and service users' preferences. There may be commonalities between job roles, but it is unlikely that roles will be the same across different localities. Service improvement initiatives drive the development of advanced practice roles within the workforce to undertake a greater number of assessment, and diagnostic and triage tasks, to reduce the demand on the medical workforce. This appears a tacit acceptance that the individual (or groups of individuals) shape the profession. Equally, like the findings of McCann et al (2013) the individuals were far more influenced by the needs of the organisation than the aspirations of the profession.

This acknowledgement by the CSP means a significant time delay between practice in the workplace and advocacy by the profession. Fluidity of role boundaries is one strength of the ESP role which bridges traditional medical and physiotherapy disciplines. However, this very strength could also be perceived as a weakness. Fluid role boundaries can also represent a tension, for example, in terms of role clarity, the level of education preparation required for the role and negotiation and agreement of practice by other stakeholders (including patients) within the clinical domain. Entrepreneurship in clinical practice involves developing and extending the responsibilities of physiotherapists through improvement, evaluation and expansion of roles and tasks undertaken. It could be argued that this innovation means the participants were fulfilling the role of the consultant physiotherapist as described by the CSP. The role of the profession then is to justify and enable these advanced tasks and skills to be

embedded within the unique function of the physiotherapy profession, rather than simply the individual performing delegated tasks to relieve other professionals' workload or as a doctor-substitution.

For example, the experiences of the participants, in terms of institutional work, indicates some weaknesses in the work of education, identity and theorizing associated with maintenance of institutional change. The CSP could focus on addressing these weaknesses by lobbying Health Education England for post graduate funding and work with universities to deliver the training. It could then then re-focus on re-advocating, re-defining and re-vesting attributes to the role which can then be advocated by ESPs in the workplace. This is likely to be a protracted, intensely political task as education funding is squeezed by central governments cost efficiency savings (Iacobucci 2017).

In terms of identity it could more robustly advocate the career framework (CSP 2016) so that advanced practitioners and consultant physiotherapists become the norm in the NHS. In doing so ESPs, physiotherapists and the CSP could engage in the work of theorising to establish such roles and practice within the physiotherapy profession that becomes accepted by other actors. Theorizing actors' roles defines the way they can gain legitimacy and enables institutional change and the subsequent diffusion of those roles and practices into the institution (Mena and Suddaby 2016), in this case the NHS.

The individuals in clinical practice through institutional work, create or adapt jurisdictions or boundaries. If these are accepted in the work place the changes can be collated by the profession and used to advocate and define a new professional role. The CSP through advocacy can maintain the role locally, create the role nationally and use the case studies and evidence to challenge the status quo. They could begin this change by increasing the prominence of the ESP network. It would be an appropriate time to rebrand and relaunch it with the physiotherapy career policy of advanced practitioners and consultant physiotherapists. A new name and a new focus on creating a normative network to support the maintenance work of such roles.

Due to their access to central government the CSP is important in influencing future legislation. Heale and Buckley (2015) argue that legislation should be written in such a way that it supports role clarity and credibility. Legislation should offer health professions legitimacy through credentialing procedures such as registration, certification and licence as well as a defined scope of practice, authorized clinical tasks and entry requirements (RCN 2012 Ryley and Middleton 2016). It can improve organizational understanding of an advanced practice role and lead to less variations in practice and improved role clarity (Scanlon et al 2016). In addition, if correctly drafted it can minimise inconsistent expectations, restrictive employer job descriptions, role conflict, role overload and variable stakeholder acceptance. (Morrison & Benton 2010, Carney 2015).

Conversely, if regulation is inadequate, it can impose its own form of practice barriers (van Soeren et al. 2009). As the International Council of Nursing point out 'regulation is fundamental to the identity, structure and type of services a professional can offer, the way nursing is regulated can either facilitate or impede its ability to remain relevant and its capacity to offer needed services' (ICN 2013, para 2). Thus, while advanced practice roles may be strengthened by regulation, the regulation must be clear and adequate to address the full scope of practice. It also needs to mitigate competition between healthcare professions and additional barriers to practice.

The CSP has been reticent about defining the scope of physiotherapy. It argues that practice is a dynamic process and to define boundaries would stifle innovation and make the profession less adaptable to change (CSP 2013). It has made a more recent contribution, in providing a policy document, which argues for the roles of advanced practitioners and consultants but leaves the implementation to local hospitals and health care trusts (CSP 2016). It supports the existence of advanced physiotherapy roles but stops short of describing them. The proposal of a title for such roles gives them an identity within physiotherapy and promotes its value within healthcare. However, the ongoing development and refinement of the role is being conducted by individuals in the workplace responding to organisational stimuli and demands.

Hence the importance to the profession of understanding the experiences of those practitioners engaged in extending physiotherapy roles.

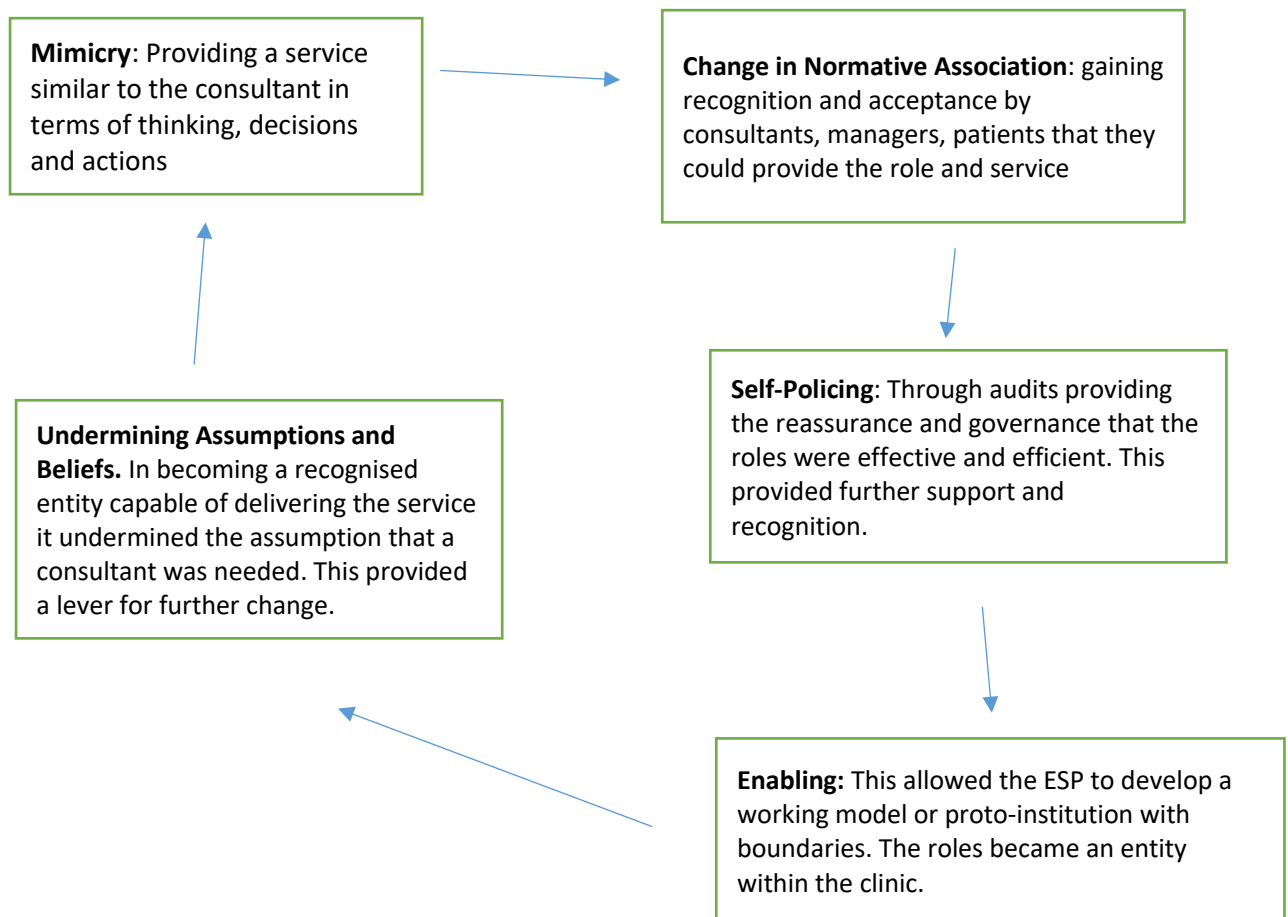
Lawrence and Suddaby (2006 p220) link the forms of institutional work into three 'stages' which together 'describe a rough life cycle of institutional work that parallels the life cycle of institutions,' The premise suggests that institutional change happens in a linear manner and that institutions are developed to replace others as they decay. However, from the experiences of the participants, and the work of the CSP, institutional change can simultaneously disrupt established institutional arrangements to create space while being able to create and maintain change to fill the space created. The participants used different aspects of institutional work to create and maintain their role and the CSP collated and used the institutional work of the individual to engage in its own institutional work at the macro level.

As marginal actors, the participants, found that some forms of institutional work were easier to engage in and led to the creation and maintenance of their role. The lack of a career framework meant that they forged their own trail through professional boundaries and negotiated institutional arrangements with other professions within a changing organisational culture. The experiences of these participants provide an insight for others considering changing roles and for the physiotherapy profession in how to support such change. It enables these participants to be viewed as institutional entrepreneurs engaged in change through institutional work.

To provide an overview of the impact of institutional work on the experiences of the ESPs the following model maps summaries the discussion and the ways the diverse types of institutional work evolved.

7.3.5. Summary

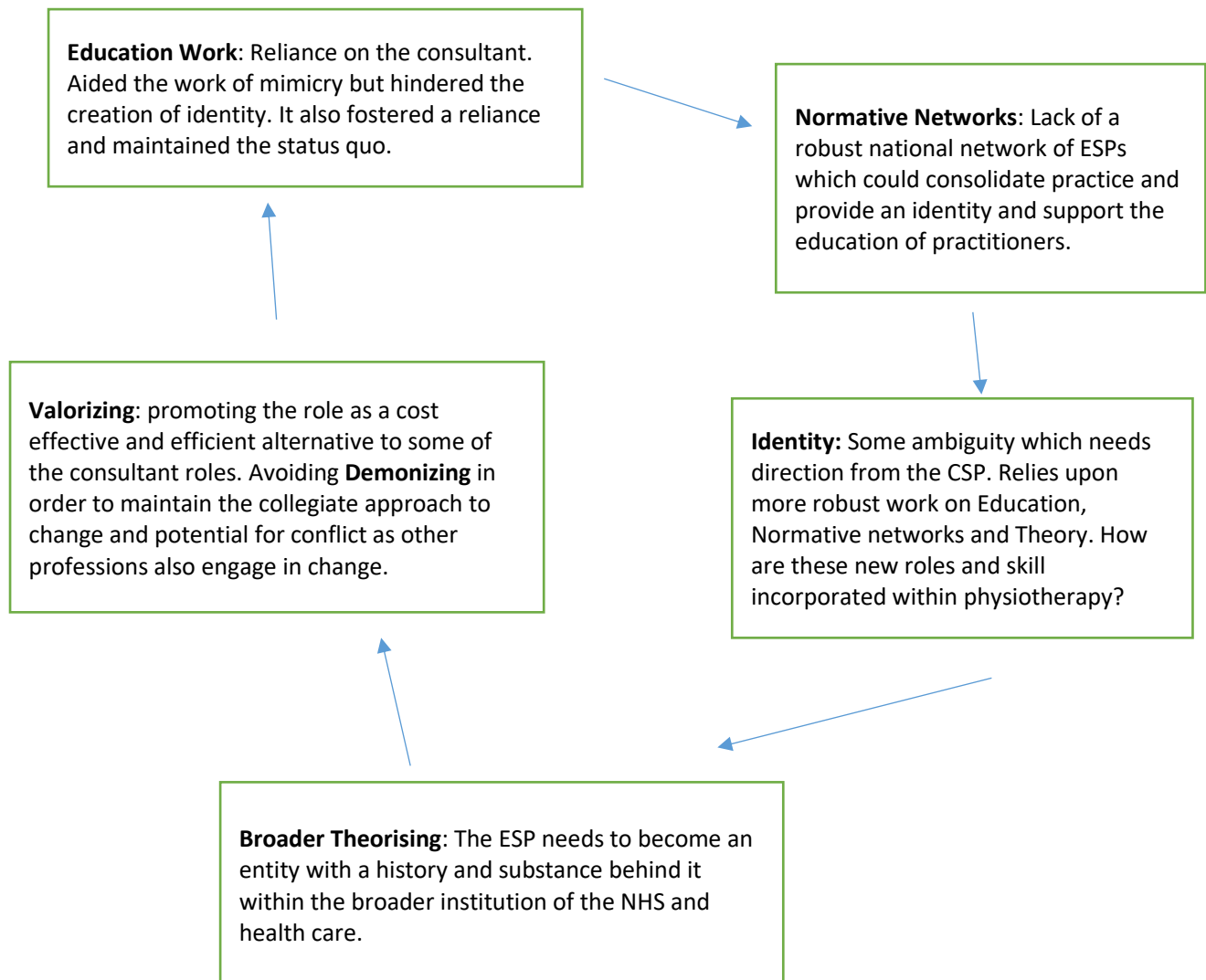
Successful Types of Institutional Work



There was no strategic direction or end-point and the adaptations were non-linear. They arose out of organisational demands and so the changes in normative associations were local features confirming Dawson and Gharzi's (2004) assertion that what happens in one hospital might not be considered appropriate in another one. These changes were individually driven which produced difficulties with succession planning.

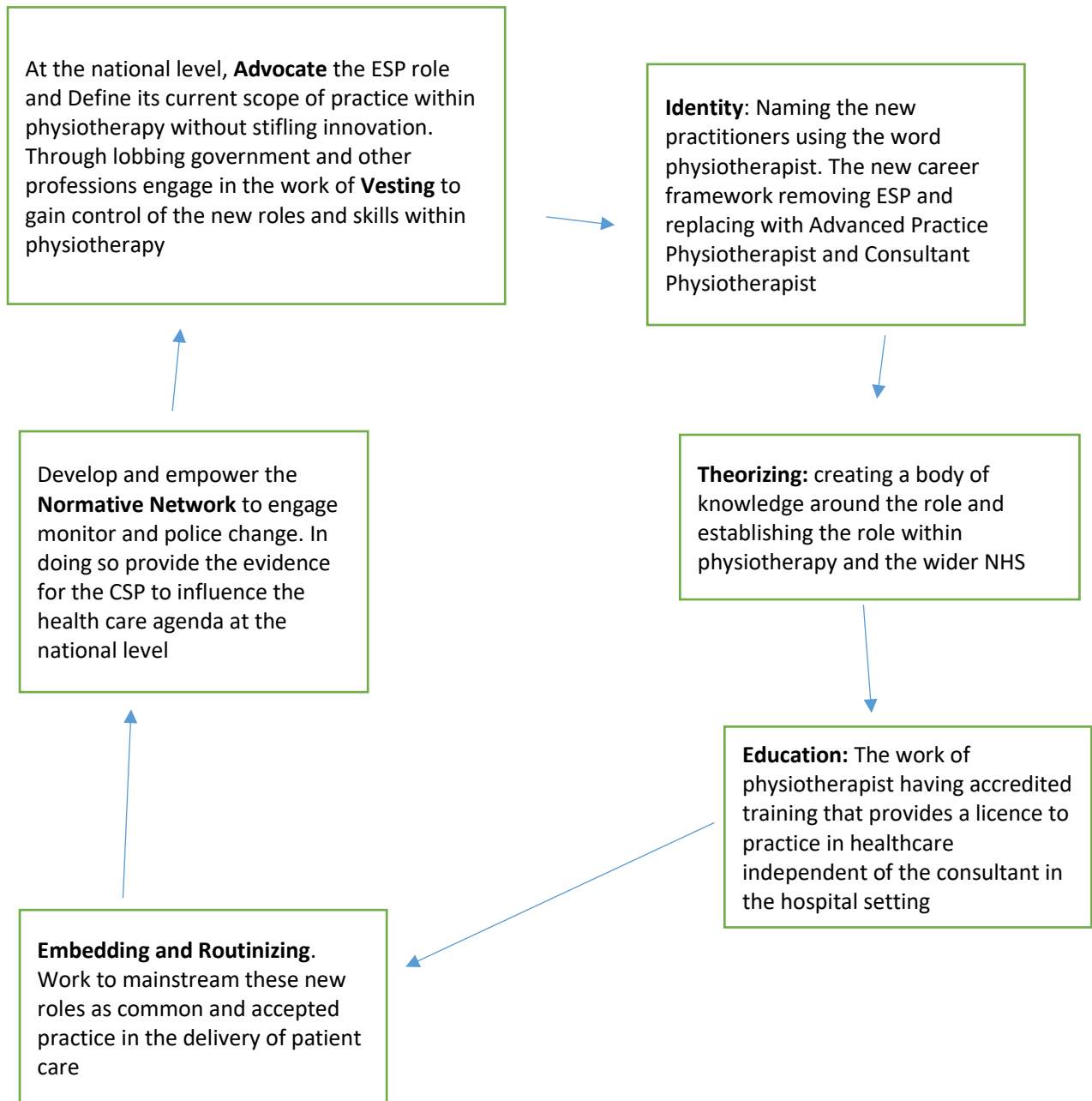
Types of work which were less successful are highlighted in the following diagram.

Less Successful Types of Institutional Work



Considering these less successful types of Institutional work, it is argued in this thesis, that the CSP can now focus its institutional work on addressing these issues and provide support. This is highlighted in the final diagram summarising the discussion.

The Institutional Work of the CSP.



The CSP in engaging in these types of Institutional Work provides the reason for its role as the professional body and its place within the larger institutional framework of the NHS.

The following chapter begins by arguing that this study has rigour and trustworthiness that enables the reader to gain an understanding of developing ESP roles. It then returns to the aims of the study and highlights new understanding of ESPs' experiences. In viewing the

ESPs as institutional entrepreneurs engaged in institutional work a new appreciation of their experiences is uncovered which provides insight into changing professional remits and roles.

Chapter Eight: New Understandings

8.1. Introduction

This study was conducted in 2012, since then the title Extended Scope Practitioner (ESP) has been abandoned by the Chartered Society of Physiotherapy (CSP) in favour of Advanced Physiotherapy Practitioner (CSP 2016). Physiotherapists have successfully achieved independent prescribing rights (CSP 2014) and the NHS still strives to meet increased demands and budget restraints (DH 2016). In this final chapter, the argument is made that the insights drawn from the study are relevant now and in the future for the profession and that in understanding the participants' experiences a contribution is made to the concept of institutional work and changing professional roles.

For the first-time ESPs are viewed as institutional entrepreneurs engaged in institutional work. This new view point provides the opportunity to understand the experiences of the participants within an institutional context. In considering how the participants created and maintained their role, while disrupting the institutional arrangements of other professions, it puts the ordinary individual at the centre of institutional work. It provides a common language and framework for examining the work of the individual and the work of a profession. It offers an insight for others considering change within a profession, and for professional bodies, to understand the work and the support needed to implement and maintain new professional roles.

Qualitative analysis is inherently subjective because the researcher is the instrument for analysis. The researcher makes all the judgements about categorizing, de contextualizing, and re-contextualizing the data (Langdrige 2007). Therefore, a test of trustworthiness is for the accounts to allow the reader to get a feel for what it is like to have the experience (Todes and Holloway 2006). Alternatively, that the practice of physiotherapists and others would be enhanced by understanding how individuals lived through and made sense of an experience (Starks and Trinidad 2007). This chapter begins by reflecting on the rigour and trustworthiness of the study.

Some may question why this section appears in this part of the study. My reasoning is the following, at this point readers will have formed an opinion, based on the methodology, method, outcomes and discussion, as to the credibility and relevance of the study. Different authors ascribe different means to demonstrate the quality of qualitative research. This chapter followed the four broad criteria suggested by Yardley (2000) that include: sensitivity to context; commitment and rigour; transparency and coherence and importance and impact. This next section outlines the assurance measures put in place to ensure the credibility of the research and the researcher. If this can be accepted, then the findings of the study can be considered as providing new knowledge to the experiences of ESPs and understanding those experiences as individuals engaged in institutional work.

8.2. Rigour and Trustworthiness

The interpretivist approaches, taken in this study, focused on understanding the participants and finding out what events meant to them, how they adapted and how they viewed what had happened. From these subjective experiences themes were identified. In qualitative research, there is less a focus on generalisability and external validity but more on reliability and internal validation (Carpenter and Suto 2008). The data needs to accurately represent the attitude, perceptions and views of the participants but also allow the reader to follow the footsteps of the researcher. Being sensitivity to context challenges whether the researcher has focused on the participant's view of the lived experience. To answer this, it is worth reiterating that the study complied with the ethics committees and the design of the study was set in the real world with interviews conducted in the hospital setting. The participants put themselves forward to take part and freely gave of their time and experiences. There is within the analysis a large number of transcripts enabling the voices of the participants to describe the phenomena. The length of the interviews and the enthusiasm of the participants to talk about their experiences of being an ESP illustrate the focus on the context of the study. None of the

participants altered their transcribed interviews when returned to them or made amendments. This suggests that the interviews and transcripts captured what the participants wanted to say. In terms of commitment and rigour to this study, this can be demonstrated in several ways. Firstly, the length of time over which the study has been conducted beginning in 2011 and finishing in 2016 demonstrates a commitment to the study. The reason and interest for conducting the study were outlined in the introduction and are still relevant today as physiotherapy continues to develop. There is still no other published study to date which describes the experiences of physiotherapists engaged in challenging clinical boundaries. Much of this individual work remains buried within the organisations. The co-commitment with the participants was to capture their experiences, make them visible to other physiotherapists and the wider physiotherapy professions to gain an understanding of the experiences of evolving roles.

Rigour was ensured by compliance with the methodology and attention to detail in the method. The philosophical basis of the interpretative phenomenological methodology was followed in terms of capturing the participants experiences and making these clear using in their own voices in the text. The whole basis of the study was to the participants to describe and explain their experiences of being an ESP before then seeking an understanding. The method, or means of implementing this philosophical standpoint relied on semi-structured interviews as the sole source of data for the study reflects the value this study places on the participant's interpretation of the phenomenon under study. As Smith et al (2009 p56) explains, "Participants should have been granted an opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns at some length." Any interpretation of the data was based solely on what the participants expressed in their interviews endeavouring 'to make sense of the participant trying to make sense of what is happening to them' (Smith et al. 2009 p3). The actual process of analysis is detailed in the methods chapter.

Stein and Roberts (2011) argue that to reduce bias and ensure rigour, more than one researcher should be involved in the process of data analysis. In individual doctoral research, this is a problem which was accounted for by robust supervision. Supervisors challenged and checked that the final report was plausible or credible in terms of the data which have been collected and that there was a logical step-by-step path through the chain of evidence. The researcher had to argue and convince them that the findings were not based on opinion, but on a rigorous analytically transparent process. Supervision was there to assure the consumers of the research that the conclusions were logically derived from the data and that the study was systematic and transparent (Smith et al 2009 p183). Examples of the interview transcripts (including annotations), extracts from the reflective log and copies of mind maps used in the analysis are included in the appendix 8 (p 231-235) to demonstrate transparency in the research process and attention to detail.

Coherence within the study describes the way in which elements such as the research aim and objectives, method, reflexivity and outcome match the methodology. (Ballinger 2006). The research followed an interpretative phenomenological tradition which culminated in many months of writing and crafting a narrative to explain the experiences of the ESPs in terms of the themes discovered from their interviews and written transcripts. The understanding of these experiences as institutional work is consistent with the methodology. Suddaby (2010 p16) argues that phenomenological methodologies share an interpretative heritage with institutional work and share the same philosophy. As such, phenomenological methodologies are “both pertinent to the purpose and apposite to the assumptions of institutional work scholars.” There is a consistency throughout the study with the phenomenology methodology, method and interpretation.

Finally, the importance and impact of the study, or as Smith et al (2009 p183) describe it, “the principle about a significant contribution whether the final product tells the reader something interesting, important, or useful.” This is outlined in the previous section, and continues in the next where, it is argued that the research adds to the knowledge within the domain under

investigation and that the role of the researcher is accounted for in a way that is consistent with the orientation of the research.

8.3. Originality of the Work

There has been a paucity of research on the experiences of being an ESP. This study addresses this gap and meets its first objective, by capturing the experiences of ESPs working in acute hospitals, in several clinical specialities, not just orthopaedics. Previous studies described newly created ESP roles (Dawson and Gharzi 2004) or the implementation of new practice (Aitkins 2003). Uniquely, this study captures the experiences of established ESP reflecting on the creation and development of their role over an extended period (on average seven years) and the impact of future change. Like previous studies, desire to learn new skills and knowledge in a clinical area they were passionate about was a driving force. What becomes clear is that this needed to be coupled with determination to create or seize opportunities. This involved a degree of risk in terms of challenges to face and uncertainty about outcome or result but also demonstrated a confidence from the participants in their ability and positive attitude to the potential risks involved.

The participants were self-motivated and resourceful with an understanding of the environment in which they worked. They were forward looking in terms of their role and had the confidence to negotiate with powerful actors (such as consultants and managers). They worked with others to negotiate boundaries and clinical tasks and were adaptable to change and resilient to setbacks. The participants created an educational framework, which did not previously exist, supplemented over time with additional courses to define their role and the tasks they could competently practise. They moderated and adapted their language and communication to the target audience, focused on addressing their need, minimising risk and portraying their role as a solution.

Like the experiences of participants in the studies Dawson and Gharzi (2004) and Aitkins (2003) of physiotherapists engaged in changing clinical roles, there was still a reliance on the consultant for training and an emphasis on establishing and maintaining a good professional relationship with consultants. However, in contrast the ESPs in this study were much more able to negotiate their role, make their case, deal with set-backs and still see a bigger picture. The participants in the Dawson and Gharzi (2004) study reported being much more influenced and restrained by the consultant. It may be as Participant D commented that things are changing, “consultants are much more constrained by management pressures.” But also, the participants saw a bigger picture involving professional change and were willing to take risks, even if it meant challenging the consultants` position.

Considering the participants as institutional entrepreneurs provides a means of understanding their experiences of the changing role of physiotherapy as institutional work. It illustrates how individuals in marginal positions within an organisation can instigate and maintain change that impacts on that organisation and within a profession. The participants, through their conscious decision making, engaged in a process over many years which extended their clinical roles and skills. When they began these changes, there was no pathway to follow and each had to create and develop the role, working with others, with no clear focus on what the final role would look like. They were developing their own clinical practice and indirectly the clinical practice associated with physiotherapy. The participants were doing the mundane work of institutions without necessarily being intentional in the narrow sense of institutional work as ‘purposive action aimed at creating, maintaining, and disrupting institutions’ (Lawrence and Suddaby, 2006 p217), but in the broader sense of accomplishing their practical work which ended up reconstructing existing institutional order.

Smet, Morris and Greenwood (2012) argue that the pressures to get the job done produces practice driven changes in day to day work. These can be consolidated within an organisation before radiating out to the field level and impacting on institutional arrangements. The experiences of the participants supported this argument. Practice changes at the local level

gained acceptance within the organisation before being used by the CSP to advocate institutional change within itself and physiotherapy's relationship with other professions. The participants opted for market-driven, independent actions, which, nevertheless, created positive field-level outcomes for the profession. Like the findings of Bevort and Suddaby (2015) the successful adoption of a new logic required a clear future-oriented identity or role. However, rather than a definitive outcome the participants followed a course of action to create and maintain a clinical role with additional clinical skills and responsibilities for patient care that was different to their existing role. The focus was on developing skills and knowledge that moved the role towards a new remit without being sure of what the end-point would look like.

The participants had a desire to learn and extend their role in a clinical area they were passionate about and in doing so achieved greater status in their organizational fields. This means that institutional entrepreneurs may not only pursue institutional change for its intrinsic value, but they may also use institutional change projects as a vehicle for improved social position. Like McCann et al (2013), the ESPs were influenced by the needs of the hospitals to meet demand and targets. However, unlike the paramedics they did not react to change by attempting to maintain their role and status but took the opportunity to change and create a new identity.

The experiences of these ESPs demonstrate the assimilation of the prevailing institutional logics into their language and thinking. All incorporated (or adapted) the medical way of examining and framing medical conditions. They learned to think and act as their consultant mentor would act. For some this challenged their previous ways of thinking and the clinical role they were undertaking. This may have been compounded by working in isolation from physiotherapy colleagues. Further, unlike previous studies the participants explain their reasoning and experiences of wearing or not wearing a clinical uniform. For those sure of their ESP role within physiotherapy the uniform confirmed this. It was a source of professional identity and pride, they wanted to be recognised as a physiotherapist. For others, the uniform and identity as a physiotherapist did not confer the status or respect they associated with the

ESP role. They wanted to be different. To paraphrase Participant I, they did not want to be viewed as an ordinary physiotherapist. They wanted recognition and status.

The participants in their experiences assimilated the management or business logic of the organisation. They were subject to the institutional constraints, such as cost reduction, increased clinical demand and competition from other providers, but they also used these pressures to argue for change and the development of the ESP role. Previous studies have focused on the relationship with consultants but this study highlights the increasing importance of other actors particularly managers and nurses. ESPs must understand the business models in clinical services, the institutional work of other professions, such as nursing and the institutional constraints that impact on practice. In considering the participants as institutional entrepreneurs engaged in institutional work their experiences can be viewed as “the purposive actions of individuals and organisations aimed at creating, maintaining and disrupting institutions” (Lawrence and Suddaby 2006 p215).

The participants along this journey became skilled negotiators, fluent in the language of different actors. They became adept at framing issues, putting the argument in different ways for different people. Waldron et al (2015 p133) describes rhetoric as “the strategic use of persuasive language that simultaneously reflects and manipulates target audiences' meaning systems.” Suddaby and Greenwood (2005) argue that institutional entrepreneurs use rhetoric to transform other field members' perceptions of reality, motivating these audiences to accept and enact profound change. For the consultants, it focused on reducing workload and meeting the needs of the patient. For the managers, it emphasised improving efficiency, providing cost savings with minimum risk. For the patient, it was convincing them that the examination and outcome they would receive would be like that of a consultant. For others, it involved creating an environment that accommodated the roles of their professions through negotiation.

The participants were politically astute and aware of the context and constraints in which they worked but also, adept at providing a solution to a problem at the right time. Their narrative reflected the incremental nature of change within windows of opportunity (like the introduction

of technology for Participant H or the clinical service review for Participant J). Unlike the previous findings of Aitkins (2003) and Dawson and Gharzi (2004), the ESPs were not passive recipients of medical knowledge but active co-constructors of the role. They constructed and policed their own boundaries and provided evidence through audit of their competency and clinical outcomes. They negotiated and agreed tasks and roles with nurses to ensure acceptance and minimise disruption. They also self-evaluated areas of practice they would not pursue because of the power of incumbents or agreed sharing of roles.

Empson et al (2013) emphasise the work of advocacy needed by new people in new management roles to gain support from senior partners. In contrast, the ESPs in this study were already in place and known to the consultants and other healthcare staff. Their approach was subtle in that they created their framework to the existing meanings of the dominant actor (the consultant) and in doing so developed a relationship on a common basis of understanding. As Topal (2015) suggests, institutional work should be seen within the context of relationships. Marginal actors can be a source of novel ideas or solutions but do not have the resources to conclusively establish a new framework. This study confirms that these relationships need time to develop and successes and setbacks need to be managed by ESPs. They understood the dynamics of the domain, identified the key actors and developed the skills to negotiate with political sensitivity to the healthcare demands and professional practice within the clinical field they intended to develop.

The participants gained this understanding by being aware of the demands on the consultant, providing a solution, demonstrating their competency, minimising risk and reducing the work for the consultant. The participants' experiences can be understood if considered as institutional work. The work of mimicry by the ESPs provided the opening for the role as a solution to the above demands. There was no educational framework and the participants relied on the consultants for education and training. They aligned their personal framework of being an ESP with the dominant framework of medicine and in doing so engaged in the work of creating the role. It could be argued that the work of mimicry was necessary because of the

lack of an educational framework within physiotherapy. But the work of mimicry produced more than this. In learning the skills, and more importantly discovering how the consultant would think and deal with clinical cases, they reassured other actors that their clinical examination and processes would follow the consultants' model. They were not "hand-maidens" to the consultant because they actively and progressively advanced their role. Mimicry was one form of work used to create the role but the participants were also engaged in maintaining the ESP role and subtly disrupting part of the consultant's role with hospital managers.

There is a similarity in the type of work of the participants and the initial founders of physiotherapy in the UK. Thornton (1994) in documenting 100 years of physiotherapy refers to articles in the British Medical Journal of 1894 raising concerns about activities which might be occurring in "massage houses" by supposed masseuses and masseurs. The scandal of massage as a euphemism for other services impelled the founding of the "Society of Trained Masseuses". The founders aimed to protect massage from the "degradation that surrounds it and make it a safe clean and honourable profession for British women" (Thornton 1994 p12). In doing so, Parry (1995) argues that the founders traded autonomy for orthodoxy and accepted both the patronage and wisdom of doctors. The bargain they struck with medicine allowed members of the Society of Trained Masseuses to practise if they justified what they did in the doctors' terms using the medical model of healthcare.

The participants used the consultants' model of healthcare, learning to think and act like their consultant mentor. This maintained the status quo, in that, the consultant was the dominant clinician controlling and monitoring the education and role development of other professionals (Currie et al 2012). However, the participants were not passive recipients. They were resourceful in identifying training needs and how to access them. Several participants describe finding the hoops and then jumping through them. This took a considerable amount of time and effort. Dawson and Gharzi (2004) found ESPs reliant on consultants for training and recognition as competent. In contrast the ESPs, in this study, were more proactive in negotiating the type of training and the scope of practice. They defined the work they would

do and provided the evidence that they were competent, efficient and effective. They all had completed a Master`s degree in their clinical area to support some of the work they were undertaking.

The role development of the participants is better viewed as cooperating or coalescing (Zietsma and McKnight 2009) with other actors in the field when creating the new clinical role rather than the role being created and monitored by another profession. Previous studies have identified that even when qualified to perform tasks, or clinical roles that have state sponsorship, the implementation can be adapted, altered or stifled by professional and organisational pressures in the workplace pressures (Altersved et al 2011; Kroezen et al 2014; Kennedy et al 2016). In the participants` experiences this was minimised by being in-situ and growing the post organically through continued negotiation and dialogue with consultants, managers and other healthcare professions in the same clinical area.

The participants work of mimicry minimised the risk of disruption to their new roles in three ways and ultimately reduced the reliance on the consultants. Firstly, the participants ensured a framework of training, education and support was in place. They used the factor of increased clinical demand to offer a solution by taking on discrete areas of clinical work previously performed by the consultant. They made themselves available for training and incorporated the consultants` way of working into their own practice. Secondly, they pro-actively published audits. This served two purposes: one to counter any argument of patient risk and secondly to consolidate the role by showing its effectiveness and cost efficiency. The number of audits conducted by the participants, maligned by Kerstein et al (2007) as poor evidence and research, can now be seen in the context of policing and used to promote the changing role within the organisation.

Thirdly, Currie et al (2012) identified how hospital consultants invoked concerns of risk and present themselves as `arbiters of risk`, to make the case for why the delivery of services might be delegated, rather than substituted. In contrast, the participants` experiences demonstrate how they co-created and defined the role with the consultants, negotiated the training and

education (including post graduate courses), policed their own practice and valorised their outcomes. In doing so they worked to have the role recognised and through negotiation with managers began to distance themselves from the consultant. They agreed a working model and boundaries (Enabling work) and made the work routine and part of the organisation (Embedding and Routinizing work). By conscientiously mirroring the practice of the consultant they provided a surety of what the patient could expect in terms of examination and outcome. By building up a relationship of mutual trust and respect with the consultant the participants created a new role and remit different to established physiotherapy practice and routines. The ESPs become a substitute for the consultant: receiving their own referrals; conducting examinations; referring to other healthcare professions and discharging patients back to their GPs.

On reflection, there is a note of caution based on the success of the participants' work of mimicry. The current study highlights the success of mimicry: if something looks like, acts like and has the same results as the original it is likely to be accepted. Further, if that new role has a cost advantage it is likely to appeal to cost conscious managers. This highlights two issues. The first is the time taken for change in an organisation to be adopted by a profession. The first data on an ESP role was published in the late 1980s (Byle and Ling 1989) yet the inclusion of such roles into a career framework has taken twenty-seven years (CSP 2016). The second links with the first, in that, change by individuals, without the framework of a macro structure supporting it, is unlikely to be sustainable. The participants identified a lack of succession planning in their roles and with the recent changes some feared that their roles will be lost. This should be a concern for the CSP and area for sustained institutional work in terms of education and theorizing.

The institutional work of mimicry and policing provided the evidence to engage in the work of changing normative associations. In gaining acceptance of the role the participants could begin to construct an ESP identity. The participants demonstrated that marginalized actors can produce change. They could have used the institutional work of valorising more robustly

to demonstrate their achievements but were aware of the sensitivity of other professions and their own position in terms of grading. All the participants emphasised positive working relationships and accommodation of other professions but simultaneously they were undermining the assumptions and beliefs that the clinical work could only be delivered by consultants. They consolidated this position in discussions with hospital managers emphasising cost efficiencies. These arguments were later used at a national level by the CSP advocating the safe, efficient and effective practice of ESPs to meet rising health care demands.

At the time of the study there was increased demand with enough work for all. It is likely with cost pressures and competitive tendering there may be a change in negotiation and accommodation. This potential difficulty, of arriving at a shared agreement of tasks and boundaries, can be seen in the experiences of some of the participants in their professional relationships with PCTs and community services. The implementation of market reforms has transformed the NHS from a single national healthcare provider to a fragmented conglomeration of competing services delivering healthcare under the umbrella of the NHS brand (Sturgeon 2014). In summarising health care reforms, Niemietz (2015) argues that to take competition to a higher level, the market must be moved from static competition to dynamic competition and to a market with entries and exits. The market should include success and failure with a strict no-bail-out clause for failing providers, alongside the right of independent sector organisations to take over insolvent providers. The previous experiences of the participants in negotiating change and tasks may become one of overt competition and dispute, akin to the original argument put forward by Abbott (1988). This might impact on ESP roles due to the individualistic nature of their development compounded by a weakness of a robust normative network to champion the individuals at the macro level.

These experiences demonstrate that institutional work does not occur in isolation. While the participants were creating, and maintaining change other professions were also engaged in institutional work. The relationship with the arthroplasty nurses highlight that while one

profession wants to change another will be working to maintain the status quo and work to do so. Alongside institutional work to disrupt and create institutions, other actors are maintaining institutions and so within this dynamic process new set of institutional arrangements and boundaries gradually emerges. The participants describe how they set about creating and maintaining their role within the hospitals but towards the end of the interviews they all discussed facing change and workforce reviews. Some were worried about jobs and all perceived that things would change. This seems to confirm previous observations that there is no clear point at which an established institutional logic is destroyed and a new institutional logic is constructed (Currie et al 2012, Empson et al 2013). There is an evolution of roles that can be significantly affect by a jolt to the organisation that produces a reaction (Battilana and D'Anno 2010).

Further, in support of the argument of Currie et al (2012) the different types of institutional work, creating, maintaining and disrupting, tended to blend within a professionalized context. In none of the previous studies has the work of mimicry been so prevalent. In this study, the participants used it to create the role working with the consultants but also used the success of mimicry to argue for the maintenance and expansion of the role with hospital managers as a cost- effective alternative. Mimicry and policing provided the evidence to change normative associations and gain acceptance of a new practitioner's role. The strands of work articulated in the typology of institutional work as discrete provinces appear from the experiences of the participants less constrained. Policing was used to maintain and establish the roles but it was also part of the creating process. Identity evolved during the processes of creating and maintaining. Changing normative associations occurred during the creation of the roles and in maintaining them in the face of cost pressures. In addition, strands of institutional work occurred simultaneously at the micro and macro level. In terms of advocacy the participants strongly argued for the roles within the organisation while the CSP used the same arguments, and the evidence of success from the organisations, to press for recognition at the national level.

This study argues that the participants can be viewed as institutional entrepreneurs bringing about change rather than the introduction of a new institution. Perhaps, Waldron's (2015 p37) description of entrepreneurs more accurately describes the participants as “actors who envision changing institutions to advance interests suppressed by current institutional norms.” This description removes the assumption that it is only actors with sufficient resources that can bring about change and supports Battilana et al (2009) argument that institutional entrepreneurs fundamentally pursue change to realize their own interests.

Giddens (1979) described agency as a reasoning actor's capacity to act or not to act. Marti and Mair (2010) linked agency with motivation, will, interest, choice and the actors` ability to operate somewhat independently of the determining constraints of social structure. One of the themes, agency, identifies the participants` motivation and opportunity. It also uncovers the way the participants as entrepreneurs exercised their agency through negotiation with key players and adapting the rhetoric to each situation. There is a political astuteness to the situation and context that allows adaption and facilitates completing the task of being an ESP. The experiences of the participants add to a growing awareness of institutions as products of human action and reaction motivated by personal interests and agendas for institutional change or perseverance (Lawrence et al 2013).

Topal (2015) suggests that the structural factors of institutional work, such as institutional power positions and meaning frameworks (or logics) are important but that relationships between various actors shape the process and direction mainly by conflict or consensus. The ESPs demonstrate how they developed these relationships and articulated their decision process when considering extending their clinical boundaries. They resolved conflict by negotiating agreements and co-creating roles or decided not to engage at that time. The decision not to proceed was based on the nature of the work (as with Participant B), the organisational structure or routines (as with Participant I and the PCT) or the inability to gain access or influence more powerful actors such as commissioners of services. All these rely on building a relationship to begin the process of institutional work.

Dawson and Gharzi (2004) and Aitkins (2003), make inferences that ESPs saw themselves as different to their physiotherapy colleagues. In this study, some of the participants clearly felt different, thought differently and felt a lack of recognition for their role from others, including physiotherapists. The CSP has sought, to some extent, to minimise this ambiguity about roles by introducing a new framework which defines the advanced practitioner and the consultant physiotherapist but it has left the implementation of such roles to individual employers (CSP 2016). From the experiences of the participants, change is a gradual process and providing a career framework is a start. A search of the NHS jobs website (1/3/17) reveals 531 physiotherapy jobs but only four with the title advanced practitioner, none with the title consultant physiotherapist and twelve with the title ESP. There were no training posts and the highest grade of post advertised was band seven, one pay band below the participants in this study. It would be difficult to draw much from this but to point out that the titles proposed by the CSP have yet to gain recognition in advertised posts. The prediction from the participants that the grade of ESP posts is likely to be reduced appears to have some grounds. The lack of training posts advertised suggests that training is still occurring in-house using existing staff (similar to the experiences of the participants), or alternatively, all the available posts are filled and there are no vacancies.

Previous discussions have addressed the first objective of this study by describing the experience of being an ESP in an acute hospital. It has also met the next two aims by demonstrating the application of institutional work as a conceptual framework to understand those experiences and shown that it can be applied to marginal actors engaged in mundane day to day practice. Further, it provides further refinement to the concept by illustrating a fluidity between the activities involved in creating, maintaining and disrupting institutions. It demonstrates how the concept can add context to those experiences particularly if the participants are viewed as institutional entrepreneurs. The final aim is addressed by providing a language to consider the macro and micro activities and assess the degree of convergence between the individual and the profession and between professions who may be competing

or negotiating change. It provides a means to consider the processes and successes of different types of institutional work. For example, the experiences of the participants, in terms of institutional work, indicated some weakness in the work of education, identity and theorizing associated with maintenance of institutional change. The CSP could focus on addressing these weaknesses as outlined in the previous chapter.

The experiences of the participants are significant in terms of how physiotherapy is changing and the time lag between workplace change and advocacy by the CSP. It reinforces how workplace change, if it gains momentum, can bring about institutional change. Conversely it also highlights how local or individual innovations and change may, without the institutional work of more powerful actors, fail to develop outside of the local confines as demonstrated by the lack of succession planning experienced by the participants. The CSP through its institutional work must ensure that these roles are accepted, planned, funded and implemented. In considering this the aim of the study is met in that the experiences of the ESPs can be considered as institutional work and the ESPs as institutional entrepreneurs.

Chapter Nine: Limitations, Reflection, Conclusion and Recommendations.

9.1. Limitations

The first limitation is the passage of time. A research study of this type is always going to have a historical dimension. The experiences discussed by the participants cover on average, a ten-year period, up to the interviews in 2012. Change, which is one of the themes, may have occurred in the subsequent four years that make some of these experiences less relevant today. However, nothing further has been published and the rate of change previously discussed suggests that four years is not a long time. Therefore, the experiences of the participants are likely to be still relevant today.

Secondly, the participants were a homogeneous group situated in acute hospitals working with consultants. The experiences of the participants highlight a growing tension between primary care and secondary care in terms of service delivery and developing roles. It is therefore likely, there may be some differences between the experiences of ESP working with GPs and those working in hospitals with consultants. Thirdly, actions and institutional effects can be linked in various ways. Actors are likely to have their own ideas about who played which role in the processes of institutional change. "Success has many knights, but failure is usually someone else's fault" (Beunen and Patterson 2016 p3). Success might be over-claimed and influenced by hindsight. The study is based on the experiences of the participants and cannot account for the experiences or perceptions of others. However, there may be parts of the participants experiences that have resonance with others. This phenomenological research study has attempted to express insight in such a way that it might evoke recognition and understanding in the reader and achieve the last feature of credibility by telling the reader something useful.

Institutional work was used as a conceptual framework to understand the participants' experiences and links the micro and macro processes. It identifies work that appears

successful and other types of work that were not as well developed. The study did not set out with the intention of describing the ESPs experiences as institutional work and it may be that there are alternative explanations that can be applied. It is acknowledged that institutional change always takes places within a context, marked by a specific configuration of actors, institutions, and power-knowledge dynamics. Institutional work and its eventual outcomes cannot be isolated from this context (Beunen and Patterson 2016). Institutional work may be a means to understanding institutional change, but it is not a singular explanatory factor. There are many other drivers and dynamics shaping institutional and organizational change.

9.2. Reflection and Conclusion

To return to the aims and objectives of this study (p10-11). Parry (1995 p310) described physiotherapists as individuals “who function in the here and now to solve problems with an imperfect understanding of how they reached their current position.” The experiences of the participants confirm the first part of the statement in that they were motivated and focused on problem solving. However, it is clear they were also forward looking in terms of their professional development. They were willing to take risks, compromise and deal with setbacks if they were developing new skills and enjoying the challenge the new roles brought. They knew how they reached their current position and the hoops they had gone through. They were reflexive in their experiences and actions.

This study therefore achieves its first objective. For the first time, the experiences of ESPs from different hospitals and specialities can be reviewed. Unlike previous studies (Dawson and Gharzi 2004) this study covered seven clinical specialities not just orthopaedics. It illustrated the participants` ambitions and motivation to create opportunities to extend their remit and roles. It highlighted the personal nature of this ambition and drive to be able to practise a greater range of skills in a clinical area they were passionate about. It confirmed Kirsteins et al (2007) assertions that change was led by the individuals in the workplace but it also captured the nuances of how this takes place. This study identified how the ESP set about

change, negotiated with others, dealt with set-backs and planned future change. It identified how they responded to change in the organisation (in terms of service reviews) and the adaptive plans they considered. It showed purposeful actions when deciding to change or in not to change their roles. They were not “shrinking violets.” They arranged a framework of practice, with others, with an insight into organisational change and impact on the physiotherapy profession. There was a vulnerability in the participants’ experiences that illustrated the paradox of the ESPs shaping the institutional arrangements around them but equally the institutional constraints and threats to their roles because of cost pressures.

The impression from the interviews was of a group of physiotherapists proud of their achievements but missing some of the recognition for what they had achieved. Considering them as institutional entrepreneurs gave them this recognition. They were engaged in activity which brought personal satisfaction and the further development of a profession. This action was purposeful and the participants reflected on the changes that had occurred and probable future changes. They were engaged in institutional work.

Demonstrating that the experiences of the ESPs can be understood within a framework of institutional work meets the second objective and adds to the knowledge of the concept. The ESPs brought about institutional change in both the physiotherapy profession and the wider NHS by creating and maintaining their roles while disrupting the institutional arrangements relating to medicine. These roles were recognised by others within the hospital and by the CSP (CSP 2016). This study showed how the typology of institutional work can be applied but more importantly it provides an understanding of what is occurring. Working closely with the consultants and understanding their way of working can be viewed as the institutional work of mimicry. Through this work the participants became established and accepted and changed the perceptions of others. This study also illustrated that institutional work is a developing concept. The format initially described by Lawrence and Suddaby (2006) is too prescribed and does not reflect workplace reality. Institutional change does not involve the creation, maintenance and disruption of institutional arrangements in a cyclical pattern but occurs in

response to environmental conditions and opportunity. The experiences of the participants demonstrated that creating and maintaining work can occur simultaneously and that different work streams can be at various stages but still bring about change.

The study met its third objective by demonstrating that institutional work can be applied to marginal actors and individuals to provide an insight into their experiences. It showed how marginal actors can bring about change in professional boundaries. It demonstrated that one of the key enablers is an ability to assimilate the different institutional logics within an organisation and articulate this in a form which gains support without being a threat to established actors.

Finally, the study met its fourth objective by demonstrating how the institutional work of the macro structure (the CSP) and the micro structure (the ESP) can be analysed and understood. In doing so areas of strength and development can be identified which can facilitate change in the physiotherapy profession and maintain its relevance and importance in meeting healthcare needs within evolving health and social care in the UK.

Future studies might investigate the creation and maintenance of Advanced Practice Practitioners using the institutional work framework. In doing so it would further the development of the concept and its application to professions and institutional change. It would provide further research to add to the evolving concept from the individual perspective and provide a link between the professional association and the individual within the professions.

To answer the research question and meet the aim (p10-11), posed at the beginning. These ESPs can be viewed as actors that “leverage(d) resources to create new institutions or to transform existing ones” (Maguire et al 2004 p657) using a variety of strategies (compromise, negotiation, rhetoric and institutional work) to pursue their own interests against the rigidity and resistance of institutions. As such they are entrepreneurs. The purposeful activity, over several years, was institutional work and applying this to their career journey provided an

understanding of their experiences which readers may wish to consider in relation to continuing development of healthcare professions in a changing NHS.

9.3. Recommendations

The development of the ESP roles highlighted common experiences which other Potential ESPs and the CSP might want to consider. The following recommendations based on the study are advocated.

For others considering such roles there is a need to understand the prevalent clinical and financial demands, the changes other professions propose in response to those demands and to have the ability to synthesis this into a professional clinical and business logic that will appeal to others. The publication of papers from this study will highlight the experiences of ESPs that have successfully managed this and provide insight for others in the role or considering such roles. In publishing the details of this study other clinical professions might be able to apply the understanding gained from physiotherapy to their own extend scope practitioners. It is recommended that further studies on clinical professions extending clinical roles, using an institutional work framework, might provide additional insight into the purposeful activity of practitioners engaged in change. This would add to the development of knowledge in the ways and means professions bring about change within their own practice and the wider institutional change within the NHS.

The experiences of the ESPs highlighted the need to create an educational framework that will support future roles and provide a licence to practise. Similar to the work in Australia (Harding et al 2015) this should be linked to a post-graduate degree programme and accreditation to practise the advanced skills. This would require the CSP and ESP to develop a curriculum with Higher Education and then jointly lobby Health Education England for funding to deliver these practitioner courses. It is recommended that the CSP work at the national level, with government and stakeholders, to advocate and gain acceptance of such roles to ensure advanced practice and consultant physiotherapists are embedded within the

NHS. Linked to this is an additional recommendation that the current ESP and advanced practitioners work to create a robust “normative network” which would support individuals, disseminate new practice, maintain quality and innovation but also lobby through the CSP for recognition and planned development of roles throughout the NHS.

Supporting the above recommendations is the need for the CSP to pursue recognition of advanced and consultant physiotherapists with these (and other new skills in the future) within healthcare. This would address the issue of identity and status within physiotherapy and provide an aspirational career pathway. It is recommended that the CSP robustly publicises these roles, with case examples, that highlights the positive impacts on health care and meeting clinical demand. The expected outcome is that these roles will have an identity with physiotherapy and become embedded in routine physiotherapy practice both at undergraduate and post-graduate level.

Finally, it is recommended that further studies within physiotherapy should look at continued advancement of the profession using the concept of institutional work. Physiotherapy is an evolving profession and using the concept of institutional work provides a common language and framework to investigate changes within a profession which would inform other professions and lead to the further development of a theory on Institutional Work linking the macro scale (CSP) and the micro scale (the individual).

The outcome of this study will result in several academic papers which will be published in peer reviewed physiotherapy journals as well as journal relating to organisational studies and management over the next 18 months. The thesis, as well as being housed at the University of Huddersfield, will be submitted to the CSP physiotherapy archives and made available to other physiotherapists in the UK and internationally. The impact of the study will add to the debate on the future role and development of physiotherapy as it continues to evolve through the endeavours of individual practitioners in a changing NHS and health care environment.

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Appendix One



National Research Ethics Service

NRES Committee Yorkshire & the Humber - Bradford

Yorkshire & Humber REC Office
Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4RA

Telephone: 0113 305 0128

27 April 2011

Mr Peter Creegan

Dear Mr Creegan

Study title: An exploration of the changing roles of physiotherapists and extended practice within an evolving profession culture and changing health care environment.

REC reference: 11/YH/0105

The Research Ethics Committee reviewed the above application at the meeting held on 19 April 2011. Thank you for attending to discuss the study.

Ethical opinion

You provided an overview of the study and confirmed that there is no information available about how extended roles develop and what the relationships are with other professional groups. You are interested in identifying how these practitioners view themselves and their role and to see if there is any resonance within the industry as a whole.

The Committee asked you to explain the recruitment process. You confirmed that heads of physiotherapy departments have already given their support to the study and will identify the extended scope practitioners in their trust. You will then approach them about the study if they give permission for you to do so. This contact will be by letter or phone call. Managers will have given them an introduction to the study by this stage. The Committee asked about the risk of coercion. You confirmed that you did not think it would be in their interest to coerce their staff to take part. Members asked how you would know which practitioners wished to be contacted by him. You confirmed that the heads would let him know who was interested in the study. The Committee felt that it would be preferable for them to contact you directly.

The Committee asked why consent was being sought from managers. You confirmed that this being done as a courtesy given that their staff will be taking time out of work to take part in the study.

You were asked to explain what is meant by extended scope practitioners. You explained that this is where roles are extended to take on additional duties usually performed by other professionals e.g. pain management. There are approximately 100 extended scope physiotherapy practitioners in Yorkshire and the Humber. Members asked if you envisaged any problems in recruiting the numbers you need. You confirmed that you are confident

This Research Ethics Committee is an advisory committee to the Yorkshire and The Humber Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

about being able to recruit 10 participants to the study.

Members asked about the security of the study data. You confirmed that your PC will be encrypted and that you will carry out transcription of the interviews.

After you had left the meeting it was noted that the participant information sheet states that the interview will last for about an hour but the protocol states that it will take approximately 90 minutes. Members wanted confirmation how long it would last. The information sheet may need to be updated accordingly.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

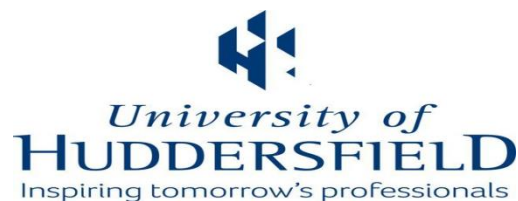
1. **Include this statement in the consent forms:**
 - a. **I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from [company name], from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records**
2. **In the participant information sheet under the heading *Who has reviewed this study* please state that it has been reviewed and given a favourable opinion by Bradford Research Ethics Committee.**
3. **Confirm that information sheets will be given directly to participants by the heads of physiotherapy and that they will contact you if they are interested in taking part.**
4. **Confirm how long the interviews will take. Revise the information sheet accordingly if necessary.**

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Appendix Two



REC Application 11YH0105-1

06.05.11

Information for Physiotherapy Managers (version 5)

Study Title: An Exploration of the Changing role of Physiotherapists and Extended Practice within an Evolving Professional Culture and Changing Health Care Environment.

Peter Creegan, the researcher for this study, would like your consent to interview Extended Scope Physiotherapy Practitioners (ESPs) who deliver your local service. If you agree I would like you to give the information to those staff, you identify for them to consider taking part.

Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information.

Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The study aims to identify contemporary changes in physiotherapy and to understand the experiences of being an ESP in acute hospital Trusts. Themes which emerge may contribute to future planning and understanding within physiotherapy of changing roles and professional development

What will I have to do?

The researcher would like you to give him permission to interview research participants that meet the inclusion criteria;

“A Physiotherapist recognised by the Trust, as an Extended Scope Practitioner assessing and treating patients.”

Once you have identified potential participants the researcher would like you to give them a participant information sheet. The researcher's details are at the bottom of the information sheet. If the extended role practitioners are interested in taking part or would like further details they will contact the researcher directly.

They are free to withdraw at any time. Their decision will be respected and any information collected will be destroyed and not used in the study.

What will be expected of participants if they take part?

The participants will take part in a one to one interview with the researcher lasting about one hour. The study needs the opinions, experiences, knowledge and feelings of being an ESP and the developing roles of physiotherapy. It is the experiences of these practitioners which is the important part of the study.

What are the impacts on clinical obligations and what do we need to provide?

Unfortunately, this is not a funded research project and there is no provision for backfilling clinical time or payment for taking part. The date and time of the interview will be at the participant's discretion to minimise impact on clinical time. The participants will be asked to provide a venue for the interview which is comfortable for them and which will allow the interview to be conducted in a confidential manner without interruptions.

The interview will last about an hour.

Are there any disadvantages in taking part in the study?

There is the time commitment for the interview and providing the venue.

Are there any advantages to taking part in this study?

The outcome of the study will contribute to the debate about the future of physiotherapy and developing practices. Themes which emerge may contribute to future planning and understanding within physiotherapy and other professions of changing roles.

Without predicting the outcome, the captured experiences of individual practitioners from several Trusts, in developing and delivering new services may provide information which allows future changes to be adapted or modified in the light of this research

This may be of value to the Trusts involved.

The participants if they wish will be kept up to date with the progress of the research.

Will taking part in the study be confidential?

Yes, all the information about your staff's participation in this study will be kept confidential.

All data will have names and place details removed to ensure anonymity.

The final thesis and any subsequent academic papers may include direct quotes from the participants to illustrate themes or common experiences. The confidentiality and anonymity of the participants and the employing Trusts will be assured and any identifiable individuals, departments, locality or hospital references will appear as an unidentifiable pseudonym.

All the data that is gathered during the study will be kept in a secure place only accessible by the researcher. The data will be kept for three years in a locked filing cabinet in a locked room and then will be destroyed.

Participants will get a transcript of their interview and will be able to make further comments if they want to clarify or add to the conversation. A copy of the transcript will not be sent to you so as to ensure participant confidentiality.

There is one caveat to this which will be explained to the participants. As practicing physiotherapists, we adhere to a code of professional conduct.

If during the interview practices are disclosed which are clearly harmful or dangerous to patient care these will be disclosed to you as the professional manager.

Any decision to act will be left to you. In this unlikely situation both the Trust and individual may withdraw their consent to be involved in the study and the material will not be used.

What will happen to the results of the research study?

The results of the study will be written up in three ways:

In thesis format, for a Doctor of Physiotherapy

As a research paper for publication in an academic journal

As a conference presentation

The researcher will offer to return to your Trust to provide feedback on the progress and results of the research.

Who is organising and funding the research?

This study is being completed as part of a doctoral research project by a practicing physiotherapist and manager. It is supported academically by the University of Huddersfield.

There is no funding for the research.

Who has reviewed this study?

This study has been reviewed and given a favourable opinion by;

Bradford Research Ethics Committee

Huddersfield University Ethics Committee

Mid Yorkshire NHS Hospital Trust Research Ethics Committee

How do we contact the researcher or get further information?

Contact Details of the Researcher

Mr Peter Creegan

Dewsbury Hospital

Halifax Road

Dewsbury WF14,4HS

Email; peter.creegan@midyorks.nhs.uk

Telephone 07770814463

Thank you for taking the time to read this information and for considering if your extended scope physiotherapy practitioners who work for you can be included in this study.

I am happy to answer any questions or concerns.

Appendix Three



REC Application 11YH0105-1

06.05.11

Participant Information Sheet (Version 5)

Study Title: An Exploration of the Changing role of Physiotherapists and Extended Practice within an Evolving Professional Culture and Changing Health Care Environment.

Your Physiotherapy manager has identified you as an extended scope practitioner and has given you this information sheet which invites you to take part in a research study. This study is conducted by a physiotherapist as part of a professional doctorate in physiotherapy.

Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Feel free to ask if there is anything not clear or if you would like more information. Contact details are on the bottom of the sheet.

What is the purpose of the study?

Physiotherapists have taken on new roles as reported in Frontline and on the interactive CSP website but there is no national framework or professional template guiding these changes.

Through interviews with physiotherapists like you, the aim of the study is to gain an understanding of the experiences of practicing with extended skills or roles. The outcome of the study will be to understand how roles develop; the challenges and the successes. The

study wants, through you, to gain an insight into the relationship of these new physiotherapy roles with other health care professionals. The subject of how skills and knowledge are acquired may come up as well as how these roles fit with physiotherapy practice, professional development and the future of the physiotherapy profession. Themes which emerge will contribute to future planning and understanding within physiotherapy of changing roles and professional development.

What will I have to do?

The researcher would like you to give him permission to conduct a taped interview with you about your role and experiences of being an extended scope physiotherapy practitioner.

The study needs your opinions, experience, knowledge and feelings of being an Extended Scope Practitioner (ESP) and the developing roles of physiotherapy.

The interview will last about sixty minutes at an agreed venue within your hospital. The venue and time of the interview will be decided by you to minimise impact on clinical commitments and suit your individual circumstances.

Permission has been granted from the Trust and your manager for the interview to take place within the Trust subject to your consent.

Do I have to take part?

It is up to you whether to take part. If you decide to take part you are still free to withdraw at any time without giving a reason and the material will not be used.

The choice to take part is yours and you should feel no compulsion to take part just because permission has been obtained from the Trust.

If you would like to take part, you are asked to contact the researcher using the contact details bellow. This will enable you to ask any questions you would like to and if still interested to arrange a convenient time to conduct the interview.

Will my taking part in this study be kept confidential?

Yes, all the information about you in this study will be kept confidential. All data will have names and place details removed to ensure anonymity.

The final thesis and any subsequent academic papers may include direct quotes from you to illustrate themes or common experiences. Your confidentiality and anonymity will be assured and any identifiable individuals,

departments, locality or hospital references will appear as unidentifiable pseudonyms.

All the data that is gathered during the study will be kept in a secure place only accessible by the researcher. The data will be kept for three years in a locked filing cabinet in a locked room and then will be destroyed.

You will get a transcript of the interview and will be able to make further comments if you want to clarify or add to the conversation. A copy of the transcript will not be sent to your manager so as to ensure confidentiality.

There is one caveat to this assurance of confidentiality. As practising physiotherapists, we adhere to a code of professional conduct. If during the interview practices are disclosed which are clearly harmful or dangerous to patient care these will be disclosed to your professional manager.

Any decision to act will be left to the manager.

What will happen to the results of the study?

The results of the study will be written up in three ways:

In thesis format, for a Doctor of Physiotherapy

As a research paper for publication in an academic journal

As a conference presentation.

The researcher will offer to return to your Trust to provide feedback on the progress and results of the research

Who is organising and funding the research?

This study is being completed as part of a doctoral research project by a practising physiotherapist. It is supported academically by the University of Huddersfield.

There is no funding for the research.

Who has reviewed this study?

This study has been reviewed and given a favourable opinion by;

Bradford Research Ethics Committee

Huddersfield University Ethics Committee

Mid Yorkshire NHS Hospital Trust Research Ethics Committee

How do we contact the researcher or get further information?

Contact Details of the Researcher

Mr Peter Creegan

Email; peter.creegan@shipleyjuniors.co.uk

Telephone 07427670947

Thank you for taking the time to read this information and for considering whether to take part in the study.

I am happy to answer any questions or concerns.

Appendix Four

UNIVERSITY OF HUDDERSFIELD (Participants version 5 date 5th May 2011)

Study Title: An Exploration of the Changing role of Physiotherapists and Extended Practice within an Evolving Professional Culture and Changing Health Care Environment.

Name of researcher Peter Creegan MSc, DMS, BA, BSc, MCSP

Interview consent form

I have been fully informed of the nature and aims of this research and consent to taking part.

I understand that I have the right to withdraw from the interview at any time without giving any reason and a right to withdraw my data if I wish.

I give my permission/do not give my permission for my interview to be tape recorded.
I give permission to be quoted (by use of pseudonym).
I understand that the tape will be kept in secure conditions.
I understand that no person other than the interviewer will have access to the recording.
I understand that my identity will be protected using pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.

I understand that relevant sections of my medical notes and data collection during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to taking part in this research. I give permission for these individuals to have access to my records.

Name of participant

Signature

Date

Name of researcher

Signature

Date

Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher

Appendix Five

Interview Schedule (format from Tod 2006)

Introduction

Explanation of the study (see appendix three)

Consent verbal and written

Promote relaxed atmosphere and answer any general questions

Warm up

Background information.

Tell me how long have you been qualified?

What areas have you worked in?

How do you see the role of physiotherapy has changed?

Main Focus

Tell me how did you become the ESP you are today?

Has your practice and knowledge changed? (Prompt look at how knowledge was gained and recognised, how has it changed?)

Tell me about any challenges have you faced along the way?

How has your relationships with other professional colleagues developed (Medical, nursing, physiotherapy and others)?

How do you see the role developing?

Do you perceive any difference between you and other physiotherapists?

Where do you see the future of the profession?

Wind down

To finish with where do you see your clinical practice in three years time?

Close

Is there anything about the experience of being an ESP you would like to add?

Appendix Six

Examples of Interview Transcripts: Participant I

350 do that

351 Steve ehm.. (We) decided *the royal we*
 352 that we would do this *Steve decided*
 353 *To prove.* initially to audited initially,
 354 *✓ effectiveness* to, effectively prove our
 355 *To show others* worth I suppose and to
 356 show we were, you know,
 357 *? feeling a threat* that we were referring
 358 *proactive ✓* appropriately, that it was
 359 something that was *who required*
 360 required because we *medics?*
 361 were, you know, very
 362 *Aware of* mindful although the
 363 *others might* medics that we were
 364 *interfer. ✓* working with and had a
 365 *good close working* relationship.

366 *is what we are doing this*
 367 *Advice here.* → is what we can do for you,
 368 *use to expand* { we would like to expand
 369 *meet demand* { the service and, you
 370 know, (laughter) while
 371 *- Feels that it* everybody actually
 372 *is a good service* agrees, it's quite funny,
 373 but it's a good service, all
 374 *Feedback.* of the A&E staff, or just
 375 about all of the A&E staff
 376 *Self justification* { certainly the juniors and
 377 the nurse practitioners
 378 *Provides an* { *love it.* They've got
 379 *alternative.* somewhere to go with
 380 their patients, *they* have
 381 got somebody to come
 382 and see and discuss
 383 things with in one of the
 384 reasons why I like to work
 385 *Nurses go to* { within that environment is
 386 *him as source* that I have contact with
 387 *of knowledge* them so they can always
 388 come along and chat with
 389 me. It's always nice to
 390 have that face-to-face
 391 contact with, ehm..ehm...
 392 I forgot what I was saying
 393 there now.

394 *team work*
 395 *Acceptance.*
 396 *? power/*
 397 *recognition*

400 Peter know that's fine because you I lead
 401 quite nicely to the next bit which is the
 402 relationship you have with other professional
 403 colleagues? ✓

404 Steve yeah right

Participant F

587 change is
588 use of own
589 role
590 on area
591
592 change
593 impacting
594
595 opportunity
596
597
598 Develop own
599 role
600 IT issues
601
602 Access to IT
603 important to
604 Choose + Book
605
606
607 Need to
608 get access
609
610
611
612 Need
613 support of
614 consultant
615

sort of structures the teams will be in. I do not know whether I will be leading the team as well as my clinical area which they are pushing for a large clinical component to any team leader role so the pressures of doing both the jobs might make it difficult to pursue whether I can actually pursue the pre-emptive work that I would need to do to get myself my own clinical list.

We also as a physiotherapy service, where not currently on pas which is the electronic booking system which is the electronic booking system which we are looking at currently which is another big piece of work. But because we were not on ~~pas~~ ^{PA's} it's not easy to setup physiotherapy led clinics where the tariffs attached to it etc, etc. so there is the IT factor which is a limiting factor at the moment. And of course the big limit will be the consultant doesn't agree that that's where he wants to lead

Participant D

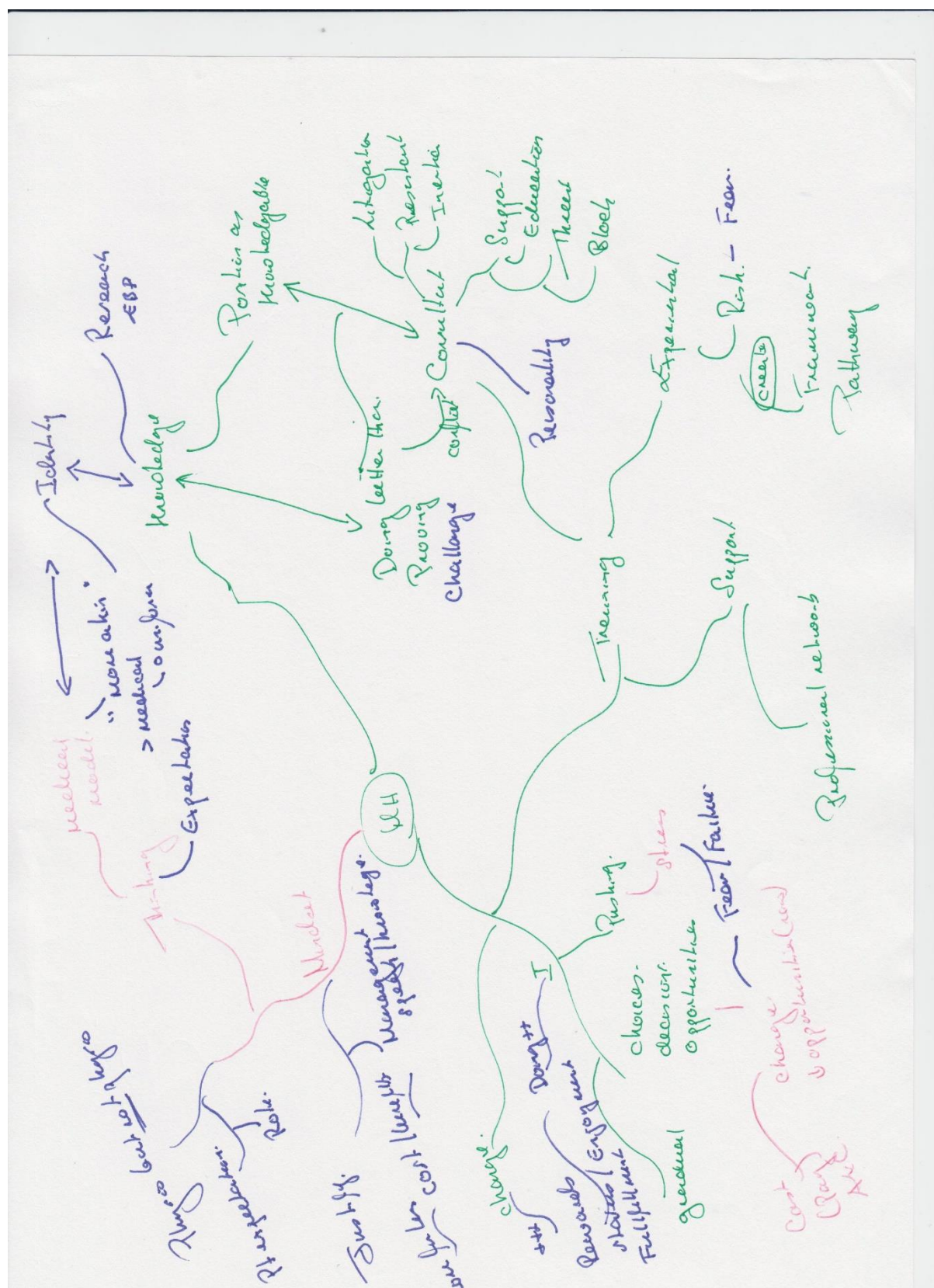
495 a physio
496 BUT
497
498 more medically
499 over-extended
500 status?
501 Assume because
502 in clinic or
503 acts like a
504 doctor
505 Identity
506 Title. →
507
508 Term ESP
509 is confusing
510
511 lack of
512 understanding
513
514
515 Feelings
516 Don't feel
517 like a
518 physio
519
520
521

wouldn't want to be anything else but I don't think my role is easily comparable with a regular physiotherapist role I think it's much more akin to a medical I think that patients tend to assume that it's the medical role and even when you introduce and explain who you are and what you're doing I don't really think they get it. I don't think that actually labelling of job role itself helps, banding doesn't make any sense to anybody is all the interchangeable ideas about ESP or practitioner just seem to fudge the issue and cloud it can make even harder for people to understand what we do. But at the same time I don't feel I..... I think I see myself as physiotherapist but if you ask my colleagues in physiotherapy they probably say that they don't see me as physiotherapist. That's probably

Appendix Seven

Examples of Mind Maps, Participant D





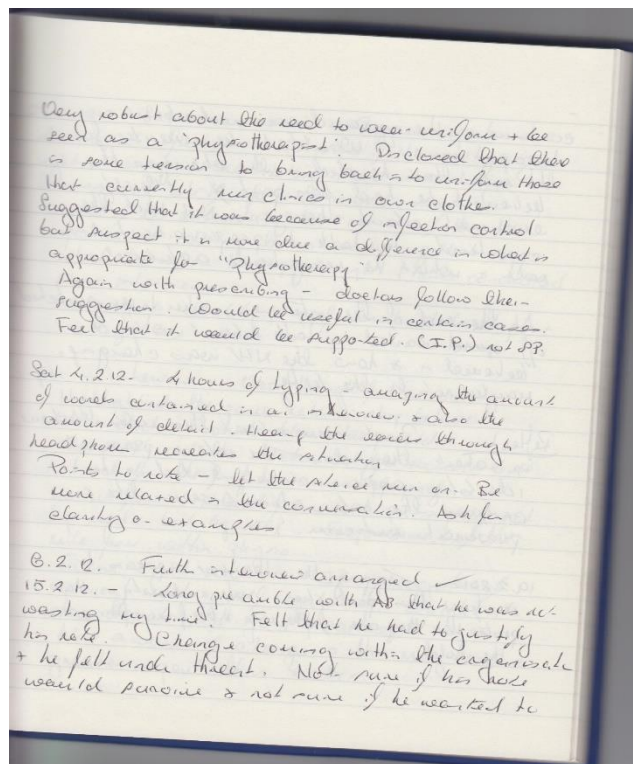
Appendix Eight

Diary and reflective notes from interviews February and March 2012.

Uniform

Reflection on interview.

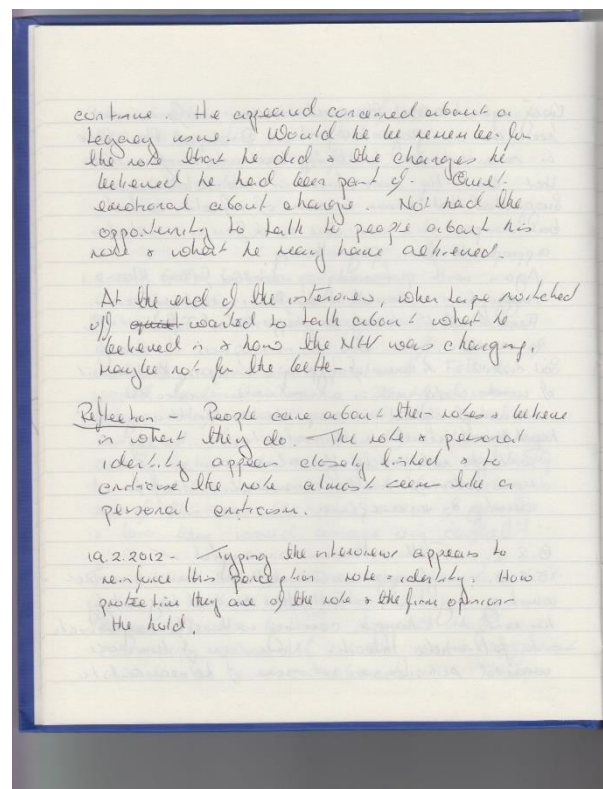
Ensuring informed consent.



Future/legacy issues

Concerns for the NHS

Care about the role

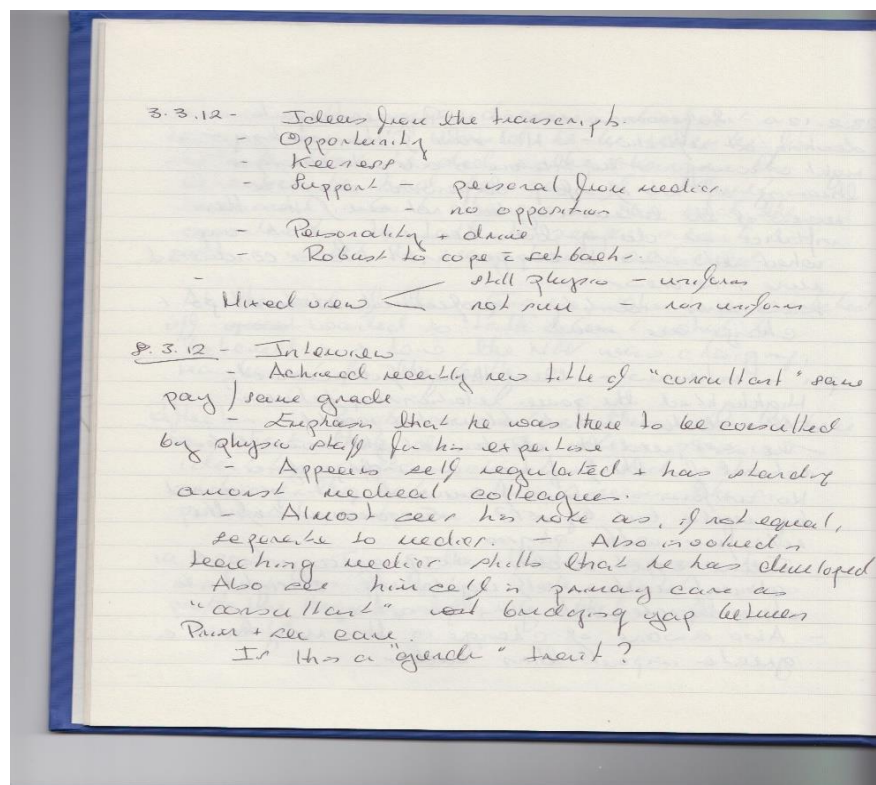


Noted ideas that occurred from the interview.

Identity/Title

Self-regulation?

Impact of Gender?

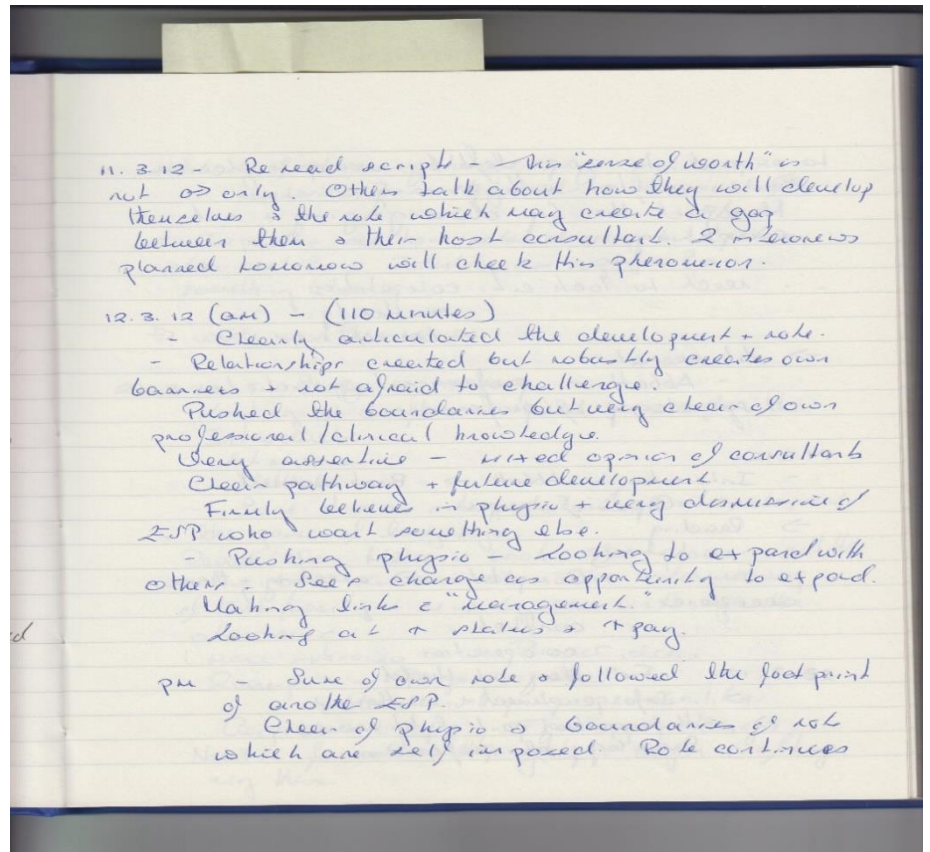


Sense of worth

Status

Diary notes from afternoon

in library October 2013.

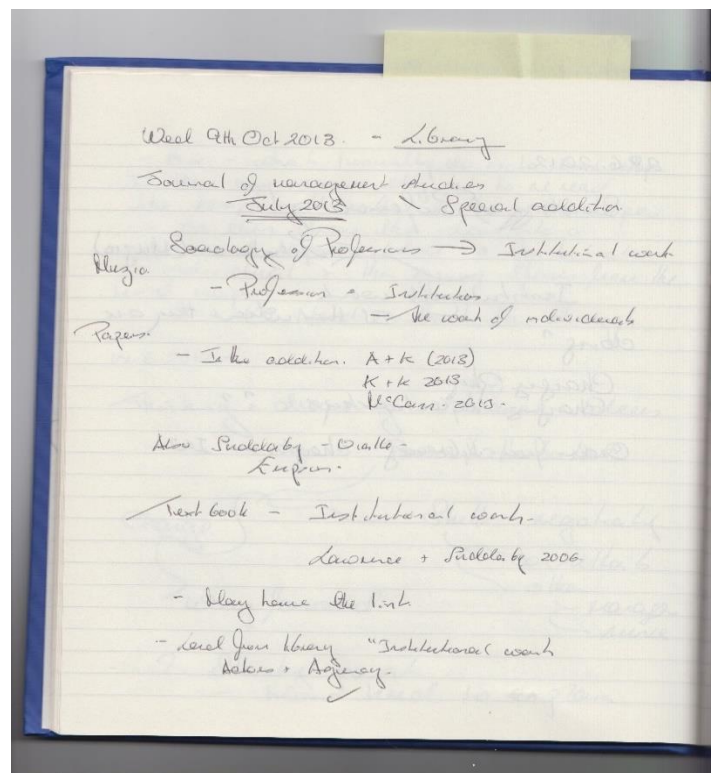


The finding of a link to explain the participants' experiences.

Journal of Management Studies

July 2013

Professions and Institutions



Institutional work

Blot Oct. 2013.

Many have the concept to explain the
experiences.

Read the book. - Institutional work.
- Original paper enclosed.

- Read Hargis et al. -
Reber et al.

If it can be applied to the individual
it can explain the work.

- Not been done before.

? Link the work of ERP to individuals.

Plan - Institutional work

→ Link
Institutional work person
(Managerial action).

Types of work.