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**INTERPROFESSIONAL
COLLABORATION: HOW IS IT CREATED
AND SUSTAINED IN INTERMEDIATE
CARE?**

Anita J. Mottram

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

The University of Huddersfield

Submission date: February 2018

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Abstract

The perceived value of interprofessional collaboration, in the provision of services, has continued to be prominent in the United Kingdom's contemporary health and social care policy, however, there has been limited empirical evidence of how the interpersonal elements of this are created and sustained within operational teams.

This qualitative research provides important insight into the experiences of National Health Service (NHS) staff working in the specialist area of Intermediate Care. It ascertains their perception of the presence of interprofessional collaboration within their respective services, the impact that this had on the staff within them and the factors that had affected its evolution.

Semi-structured interviews were undertaken during 2014 and 2015 to collect and analyse data from clinical staff working in five intermediate care services and a Constructivist Grounded Theory approach was utilised to abstract themes from the data obtained.

The findings offer an original contribution to knowledge through determining that the presence of adversity in the workplace was a significant factor in creating and sustaining interprofessional collaboration within the services in this study. A strong, collective identity for their respective social groups was formulated by the participants through situated learning, with a greater emphasis placed on interpersonal relationships, rather than interprofessional competencies.

Theorising the findings, the participants interacted in their contextualised settings, **communicating** with each other to attain and maintain **consensus**, applying **coping** strategies to manage the internal and external stressors affecting them. By working dynamically in this way, **consistency** of meanings, behaviours and culture were negotiated, offering an assurance of stability and order within settings that were frequently affected by change. These four components were labelled the *4Cs of Interprofessional Collaboration*.

The strength of these components was evident, even though an exercise to explore the constituent elements of the participants' services discovered that all of the participants perceived the construction of their respective services differently, reinforcing the presence of subjective, multiple realities.

The results of this study offer an improved recognition that creating and sustaining interprofessional collaboration is a process in constant flux to manage the internal and external stressors affecting it. It requires proactive action, mutual engagement, "**Facilitating Interaction**" and negotiation between individuals, to develop shared mental models.

Participants worked flexibly within defined parameters of practice maintaining *Dynamic Consistency* in order to achieve this.

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Dedications and Acknowledgments

This study has been a rollercoaster journey, bringing with it a multitude of emotions, but also a requirement to undertake a feat of endurance, the likes of which I had not truly appreciated at the start!

Many people have contributed to helping me stay the course and I am grateful to them all.

Thanks must especially go to my supervisors Dr Catherine O'Halloran, Dr Suzanne Smith and in the very later stages, Dr Christine Rhodes for their guidance, critical appraisals and honest opinions!

Between them they combined to recognise when to offer praise and when to firmly direct me away from the quagmire I was heading into.

I also wish to offer sincere thanks to the team leaders and staff of the NHS Trusts who participated in my research interviews. At a time when capacity was clearly limited in your respective services, so many of you gave up your clinical time readily to assist me and help direct the study.

Thanks also to Andrew Archer, my long-suffering colleague, for providing me with technical IT advice when I was struggling, for assisting me in my attempts to visually represent my findings and for keeping me smiling!

I would also like to thank my dad for proof reading the thesis, and for trying to explain to me what he thought I had written. I was particularly impressed by his ability to quote English language rules of correct grammar and punctuation from his school days of 65 years ago!

To my husband, Shaun, we got there in the end. I have been touched by how proud you are of what I have achieved and thank you for occupying yourself whilst I was busy ploughing through piles of paper or tapping away on the computer. We can now make plans for the rest of our lives.

Now, what challenge to take on next.....?

List of Abbreviations

CAIPE	Centre for the Advancement of Interprofessional Education
CCG/s	Clinical Commissioning Group/s
DH	Department of Health
GP	General Practitioner
HCPC	Health and Care Professions Council
IC	Intermediate Care
IPE	Interprofessional education
N	Nurse
NHS	National Health Service
NSF	National Service Framework
OT	Occupational Therapist
PT	Physiotherapist
PhD	Doctor of Philosophy
REC	Research Ethics Committee
SCT	Social Categorization Theory
SIT	Social Identity Theory
UK	United Kingdom
WHO	World Health Organisation

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Chapter 1 – Introduction

Introduction

The purpose of this chapter is to introduce this exploratory, qualitative study into the presence of interprofessional collaboration, within the contextual setting of intermediate care services. This chapter will present an overview of the rationale for the study, highlighting the background to the research issue within a legislative context and the chosen setting.

The research aims and questions, plus the criteria for participation in the study will be clarified and this chapter will subsequently conclude with an overview of the composition of this thesis.

1.1 Background to the study

The value of interprofessional collaboration was noted historically within the Beveridge Report of 1942 (Day 2006), which documented the founding principles of the welfare state. However, the legislative framework advocating for greater integrated services within health and social care services gathered momentum after the Alma Ata declaration (WHO 1978). The documented doctrines acknowledged that interprofessional collaboration was essential to ensure the success of primary health care, advocating that the creation of this is promoted across a variety of sectors. This offered particular relevance for the development of the diverse contextual and professional settings for intermediate care services, due to their positioning within the primary care sector.

Supplementing the declaration, increasing political demands and expectations, within contemporary health and social care policies in the UK from the late 20th Century onwards, have placed significant emphasis on encouraging integrated working. These policies acted as external drivers, within a legislative framework, to encourage workforce and service re-design with the expectation of improved collaborative practices. In order to respond to these demands, attempts to re-organise services

brought with them unprecedented and often apparently relentless organisational change, impacting on those required to operationalise the transformation.

Despite this, encouraging the development of collaborative practice has continued, with the National Collaboration for Integrated Care and Support, more recently, emphasising the need for it in their 2013 document, "Integrated Care and Support: Our Shared Commitment". This document reinforced the challenge of working collaboratively across all organisations and sectors, to provide services that were developed seamlessly around the needs of individuals to support them within their own homes. The aim was to try and overcome the institutional divides between sectors and organisations.

However, whilst this was the intent and in spite of these legislative drivers, evidence of achieving greater integrated practice remains elusive. The more recent NHS "Five Year Forward View" document (NHS England 2014) reinforced that the traditional divide between health services has remained largely unchanged since the onset of the NHS. The authors of this, as per previous government documentation, once again advocated the value of interprofessional collaboration highlighting that barriers needed to be broken down to enable the development of co-ordinated services for the benefit of service users.

Given the emphasis placed on the development of interprofessional collaboration legislatively, it may be argued that there has been limited empirical evidence to support the effectiveness of its presence within services (Wilby 2005, Hudson 2002, Irvine et al 2002). Supporting this, Pollard, Sellman and Senior (2005) note that due to the number of variables inherent in interprofessional collaboration, for example, different professionals, professions, teams and organisations, then it is difficult to prove that collaborative practice actually improves the provision of services.

This recognition had contributed to the emphasis in many extant empirical studies of objective, quantitative approaches to measuring performance indicators and outcomes when exploring interprofessional collaboration, or intermediate care services. The focus, instead, within these studies was on financial performance indicators relating to quantitative outcomes such as a reduction in length of stay within acute hospitals or a reduction in hospital admissions.

In contrast, during the process of formulating the research proposal for this study, a gap in knowledge base within the literature became evident. This indicated that a lack of attention had previously been applied to the interpersonal characteristics of interprofessional working (Caldwell and Atwal 2003, Rout et al 2010), and how the relationships that emerge from this are created and sustained. The human element of this sparked interest for me and the decision was made to explore this aspect of interprofessional collaboration further, within the contextual setting of intermediate care.

The significance of this study to the field of interprofessional collaboration is therefore that it has contributed to closing the gap of knowledge through investigating the experiences of individuals working within these settings. It has considered the meaning that participants apply to their perception of the presence of interprofessional collaboration within their services and the impact of this on their interactions and relationships with their colleagues.

The rationale for determining intermediate care as the setting within which this has been investigated is highlighted below.

1.2 The rationale for intermediate care

The term intermediate care was defined in Local Authority and Department of Health (DH) circulars (2001a) and subsequently reinforced in Standard 3 of the National Service Framework for Older People (DH

2001b), as a service designed to encourage and facilitate client's independence through working across professional and organisational health and social care boundaries.

The remit of intermediate care services is to provide short term rehabilitation programmes for service users who have experienced a change in their normal functional abilities, either due to a physical or psychological condition. By enabling individuals to attain, or maintain their optimum level of function, the intent was to prevent unnecessary hospital admission, facilitation of timely discharge from hospital or the prevention of premature admission to long term care (DH 2001a, DH 2009).

In order to achieve this there is an expectation that, within intermediate care services, staff members will overlap roles and work in new ways (Nancarrow 2004) when providing clinical interventions for service users. To undertake these interventions and work across traditional boundaries, the services required professionals to work in a more integrated and co-ordinated way to that of traditional health care services, utilising shared competencies, processes and practices when doing so.

Whilst it is acknowledged that previous studies have taken place exploring interprofessional collaboration in other settings, due to the enhanced emphasis on integrated and seamless practice within this particular type of service, intermediate care was deemed to be a particularly valuable context within which to generate rich data to answer the research questions.

In addition, whilst intermediate care is a service offering a specific type of rehabilitative intervention, it is present in mainstream health services therefore providing the opportunity to access a sufficiently large pool of potential participants.

1.3 Personal reflection

My personal interest in the phenomenon of collaborative practice developed from reflecting on my own professional experience as an Occupational Therapist (OT) working within intermediate care teams. During the 1980's, OTs were socialised to work solely within our professional competencies and certainly, initially upon qualifying, I found that the professional barriers between the different clinicians remained high in terms of segregation of roles, responsibilities and duties.

With the national legislative framework, since the late 1980s, driving the expectation of increasingly collaborative practice, the implications of this was that services were re-designed, with the workforce obliged to work in different ways to that traditionally expected of them. Whilst some challenged this change to practice, others, myself included, considered it created professional development opportunities for staff. There were opportunities to embrace the diversity of the different professions and to encourage interprofessional interactions between colleagues, to enhance core skills through sharing competencies, knowledge, information and experiences.

However, whilst organisationally the performance outcomes that this different style of working achieved was recognised at a strategic level, with hindsight, there was little consideration as to how this had impacted on interpersonal relationships and become embedded in everyday practices. This recognition encouraged further exploration of the experiences of individuals working within intermediate care settings.

1.4 Research aims

As already mentioned, with an identified gap in research relating to the interpersonal elements of interprofessional relationships in intermediate care, the overarching aims of the study were to explore the meanings that professionals placed on their experience of reality in relation to this

aspect and how they constructed and re-constructed this during the process of developing and maintaining these relationships.

Working on this basis, the main aims of the study were formulated as:

1. To explore the development of interprofessional relationships in intermediate care teams in the North of England to establish how some teams work collaboratively and others do not.
2. To generate theory identifying the factors required to create and sustain interprofessional working.

1.5 Research questions

For the purposes of this study the following research questions were addressed:

1. What are the factors contributing to the development of interprofessional collaboration in intermediate care teams?
2. How does interprofessional collaboration in intermediate care teams present?
3. How do teams maintain interprofessional practices?
 - 3.1 What factors can occur that can de-stabilise intermediate care teams?

1.6 The study population

The data upon which this study is based comprises an interpretation of the perceptions and experiences of participants to investigate the presence of interprofessional collaboration. It was therefore determined that practitioners currently working in operational roles within intermediate care services were deemed to be able to offer the most useful comparable data to achieve this. These provided the primary

source of information, obtained through the use of semi-structured interviews.

The inclusion criteria for participation were that the participants were clinically active in the service and that they belonged to the professions of nursing, occupational therapy and physiotherapy. The significance of these three professions was based on evidence, within intermediate care literature, that these professions are noted to make up the core of intermediate care teams (DH 2009) and therefore they are relevant to provide a valuable source of data.

1.7 Composition of the thesis

This section provides an overview of how the remaining chapters in this thesis are constructed:

Chapter 2 contextualises the study by offering a preliminary review of the literature sourced at the outset. It highlights concepts and the identification of the gap in knowledge relating to the interpersonal context of the creation of collaboration within teams. It reviews the development of the interprofessional arena taking into consideration the political context and developments that have taken place in the UK since the 1980s. This chapter reinforces the emphasis previously placed in literature on the performance outcomes of interventions of intermediate care services, in contrast to how interpersonal relationships are created and sustained.

It will also position the study by providing a definition of interprofessional collaboration for use within it and examine the literature in relation to the development of interprofessional teams. The preliminary discussion of the literature will provide the baseline upon which to compare the findings of this study later in the thesis.

Chapter 3 provides a rationale for why an exploratory, qualitative methodology was deemed most appropriate to use in this study as it will

provide insight into the subjective experiences of the participants. A discussion of Constructivist Grounded Theory and a rationale for choosing it and excluding alternatives is documented. An overview of the emergence of this from other versions of Grounded Theory will be briefly explored along with the philosophical position in which the study is situated and the analytical techniques utilised within this. Consideration will be given to the ontological and epistemological assumptions which led to deciding on this methodological framework and which subsequently influenced the development of the study.

Chapter 4 summarises the methods undertaken during the application of the study, providing insight into the design and the rationale for why semi-structured interviews became the method of choice. A brief consideration of why other methods were included or excluded will take place. This chapter documents the developmental stages of the study, considering ethical issues, a risk assessment for myself as well as the participants and also the very practical issues of how to recruit and interview participants. The use of memos and field notes will also be discussed as this chapter is a practical overview of actions undertaken.

Chapter 5 offers the data analysis that took place within this study. This is presented in a logical account, using extracts from transcripts to illustrate the findings. It summarises the abstraction of data with the themes exhibited in a visual format for exploration and analysis in the following chapters.

Sub-chapters 6a-d discuss the findings from the study, within the context of contemporary literature and consider the impact of the findings on the development of interprofessional relationships. The significance of how these relationships have developed and the influence of internal and external stressors on them are key sections of these chapters. A summary of the component elements of interprofessional collaboration will also be discussed here. Consideration will be given to the close interplay between

interpersonal, environmental, organisational and strategic aspects of interprofessional collaboration and the emotional resilience displayed by participants as they manage these competing factors, creating a strong collective identity in doing so. These factors will become evident in the presentation of theory which highlights the role that internal and external stressors play in generating interprofessional collaboration and the maintenance of order and stability within teams.

Chapter 7 draws the thesis to a close. It considers the implications of the research, the possible recommendations for practice but also for future study. In order to maintain an element of objectivity this chapter also considers the potential limitations of this study and applies Charmaz's evaluative criteria (2014) to demonstrate the governance of the study.

1.8 Summary

Whilst this chapter has provided an overview of the rationale for undertaking the study to ascertain the experiences of individuals working collaboratively within an intermediate care setting, the following chapter will provide an analysis of the literature available at the commencement and which framed the conceptual foundation for the research.

Chapter 2 – Situating the study

Introduction

In chapter one the focus of the study was identified as an exploration of interprofessional collaboration within the contextual setting of intermediate care services. To provide insight into how this topic was determined, this chapter will offer consideration of the preliminary review of the literature undertaken prior to, and upon commencing the study. This situates the political drivers, the historical emergence of interprofessional collaboration and the impact that this has had personally and professionally on practitioners.

Furthermore, this chapter will also recognise the wide-ranging variety of terminology and definitions used in relation to the concept of interprofessional collaboration. It will suggest that this has contributed to a lack of clarity and inconsistency in application and meaning, leading to ambiguity in developing the field of interprofessional practice.

In addition, to provide insight into the contextual setting of intermediate care, the political development and definition of criteria for these services will also be discussed, illustrating why this was chosen as a setting within which to explore interprofessional collaboration further.

But first, a brief discussion of the role of literature within Grounded Theory studies, offering an explanation as to why a more comprehensive literature review was not undertaken until the study was progressing.

2.1 Literature reviews within Grounded Theory studies

Unlike other methodologies, which require a review of the literature at the early stage of studies to formulate a hypothesis (Walls, Parahoo and Fleming 2010), within the variants of grounded Theory there is perceived to be divergence in terms of when to undertake a literature review.

Whilst Glaser suggests that an *extensive* review of the literature “violates the basic premise of Grounded Theory” (Glaser and Holton 2004, p. 8), his perspective may be argued to have been misconstrued by some authors to mean that an early review of *any* literature can lead to a restriction of theoretical discovery (Walls, Parahoo and Fleming 2010, Lempert 2007) through the potential for forcing the data into pre-established categories.

This perception may be due to the emphasis that Glaser had placed on reinforcing that within Classic Grounded Theory the theory emerges from the data rather than being directed by extant literature or theory, or the researcher’s preconceptions during analysis (Cutcliffe 2000, Glaser and Holton 2004, Holton 2008, Dey 2011, Holton 2011, Ramalho et al 2015).

In contrast, an early review of the literature is supported by Corbin and Strauss (2015) who highlight that it would aid with stimulating theoretical sensitivity and supplementary validity (McGhee, Marland and Atkinson 2007), by assisting in the determination of what is pertinent to the research questions. Given that researchers require a baseline level of knowledge in order to complete a research proposal prior to commencing a study, it is difficult to contemplate not undertaking at least a cursory review of the literature, at the outset, in order to, pragmatically, attain this.

Indeed, Strauss and Corbin challenged researchers not to abstain from the literature suggesting that they should maintain an “open mind” rather than an empty one (Kenny and Fovine 2014, p. 4). Despite the documentation of Glaser’s apparent reservations in terms of access to the literature, this is a concept that Strauss and he had previously recognised and appreciated. They had accepted that researchers do enter studies with certain preconceptions and familiarity of their topic and not as a *tabula rasa* (Glaser and Strauss 1967), unable to erase the knowledge

they had gained about the topic prior to commencing the research (Glaser and Strauss 1967).

I therefore made the decision to undertake a preliminary review of the phenomenon of interprofessional collaboration, and the context of intermediate care services prior to commencing data collection and analysis to assist in determining what aspect of the phenomenon to explore. However, I delayed a more detailed exploration of extant studies until after the first few interviews had taken place, in order to “avoid importing preconceived ideas and imposing them on your work” Charmaz (2014, p. 306).

In following this process, within the context of this study, what quickly became evident, upon preliminary exploration of the literature, was the identification that there was a lack of consistency in how interprofessional collaboration is defined, whilst recognising that commonalities between the definitions noted were detectable. To offer lucidity, the following section will document the definition of interprofessional collaboration that was applied within this study.

2. 2 Definitions of interprofessional collaboration

The phrase interprofessional collaboration is a term that is used generically to encompass a wide range of interactions and interpersonal relationships between different practitioners from different professions (Petri 2010, Oelke, Thurston and Arthur 2013). There is however, a lack of clarity and consistency in how it is applied (Suter et al 2009, Thistlethwaite, Jackson and Moran 2013).

In reviewing the literature for this section, numerous, slightly different definitions of interprofessional collaboration were derived from extant studies. Reflecting upon these and the multitude of variability and the ambiguity in definition between authors, this reinforced the complexity of

interprofessional collaboration as a challenging and socially constructed concept to explore.

In order to clarify how interprofessional collaboration was construed within this study, it was determined that there was a need for a definition that would indicate the meaning applied by myself, as author, to this concept. This will follow shortly, following consideration of the application of meaning by others.

Perreault and Careau (2012, p.256) suggest that interprofessional collaboration “may be seen as a manifestation of intensive interactions between professionals” typified by the characteristics of a common goal, shared purpose and vision (Day 2006, Hammick et al 2009). Within the literature an often-repeated definition is that of the WHO (2010, p. 36) who reported that “collaboration occurs when two or more individuals from different backgrounds, with complementary skills, interact to create a shared understanding that none had previously possessed or could have come to on their own”.

This implies the development of synergy which was noted as a recurring theme within the literature, offering the suggestion that through collaboration, professionals become interdependent, working flexibly across professional and organisational boundaries and undertaking collective decision making to achieve more together, than if they acted independently (Bronstein 2003). Hudson (2002, p. 16) concurs, reinforcing “that socialisation to an immediate work group can override professional or hierarchical differences amongst staff” to contribute to achieving integrated practice.

By working in this way, an assumption emerges that an enhancement of individual skills and competencies would be attained, with many studies perceiving that this would improve the outcome of service provision. However, whilst recognising the expectation of this within the literature, it

is noted that there was limited mention of the potential interpersonal impact of this way of working on practitioners.

Frost (2005, p. 6) was one author who did highlight the importance of interpersonal relationships though, recommending that the success of integrated working is dependent on the interaction between individuals to implement and operationalise them in “real life situations”.

This is a pertinent point as it is these relationships between individuals and the emphasis on interdependencies that D’Amour et al (2005) also identified needed to be better understood in a human process context, due to the limited conceptualisation of the effects of collaboration.

D’Amour, in conjunction with Oandasan (2005), added the label interprofessionality to the collaborative debate, proposing this as a new concept to encompass the processes which contribute to bridging the gap between interprofessional education and collaborative practice.

This term was added to the plethora already in use within the field of interprofessional collaboration with the recognition of a continuum of collaborative practice (Perreault and Careau 2012). This ranged from two or more professions working in parallel practice at one end of the spectrum as a multi-disciplinary team, through to full team integration at the alternate end, has contributed to continued differences in interpretation and definition of this phenomenon.

The implication of this variety in terminology has resulted in confusion which has been perceived to impede the conceptualisation of collaboration within studies (Xyrichis and Lowton 2008, Leathard 2009 and Reeves et al 2011 cited in Perreault and Careau).

Reflecting upon the existing definitions reviewed within the literature, none resonated with my own personal experience of interprofessional collaboration and my interest in it. For clarity of my own understanding and that of the reader, the following was therefore devised as a unique

definition for this study to articulate how inter-professional collaboration is framed by the author:

Interprofessional collaboration occurs when professionals from two or more different disciplines, organisations and/or agencies, are working together for mutual benefit and achieve a common purpose by functioning in an integrated, interdependent way across professional boundaries, competencies and paradigms.

This definition comprises a personal perception of the most pertinent characteristics of extant definitions of interprofessional collaboration that were relevant to my subjective reality of working in an intermediate care setting (Billups 2001, Mickan and Rodger 2005, Day 2006, Hammick et al 2009, McCallin and McCallin 2009, Petri 2010, WHO 2010, Nancarrow et al 2013). Content from these authors were subsequently amalgamated into the above definition that was considered to be the most relevant for this study and enhanced by my own interpretations.

The contextual setting of intermediate care has been deliberately excluded from this definition in order to increase the definition's relevance for use in other settings, recognising that realities are subjective and multiple (Perreault and Careau 2012). To summarise, the definition aims to encompass cohesive working where there are no, or limited barriers or divisions and where individuals work together as part of a social group depending on the needs of their situation.

2.3 Search tools and data bases

To seek out relevant literature, at the early and later stages of the study, a search of electronic data bases was instigated on the NHS Evidence website as the primary source. The databases searched were AMED, BNI, CINAHL, EMBASE, Health Business Elite, HMIC, Medline, and PsycINFO using the inclusion criteria of research based articles and systematic or

literature review papers on interprofessional collaboration in intermediate care services within the United Kingdom.

Despite the political emphasis within the UK on interprofessional collaboration, a limited number of studies were identified which related to this within the context of intermediate care, and this continued to be the case as the study progressed. The opportunity to compare studies that had previously taken place within this setting was therefore limited.

Having noted that this was considered to be a limitation of the previous research in this particular setting, it did, however, offer assurance that the gap in knowledge identified at the start of the study was still relevant. There were, though, studies into interprofessional collaboration within other settings that could be used for comparison.

Whilst an extensive literature review was not undertaken at the outset, the following section provides a synopsis of the preliminary literature considered that was identified as being of relevance to the phenomenon under exploration in this study.

2.4 Introduction to the literature

Ramalho et al (2015) highlights that within Grounded Theory, the existing literature comprises an additional form of data to assist with the analytical strategies of the study. It also provided assistance at an earlier stage of the study, when decisions were required to determine the area of interprofessional collaboration to explore.

From the available literature it was identified that there was an acknowledged lack of clear understanding of the antecedents necessary for collaborative practice to be developed and maintained, or the effects of these on the practitioners and service (Elston and Holloway 2001, Freeth 2001, Hudson 2002, Webster 2002, King and Ross 2004, Baxter and Brumfitt 2008, Nancarrow 2004, D'Amour et al 2005, Petri 2010,

Reeves 2010, Rout et al 2010, Cameron 2011, Croker, Trede and Higgs 2012, Nancarrow et al 2013).

The volume of authors who had highlighted these as a gap in knowledge base was sufficiently significant to indicate the value of exploring these areas further.

In contrast, a significant emphasis, within studies sourced, was instead placed at either an inter-organisational level, or on performance oriented outcomes of service delivery. Hudson (2002) and Cameron (2011) proffered a pertinent point by articulating, what they both perceived to be an assumption, by those developing policies, that interpersonal relationships would automatically develop following the establishment of interagency processes. Hudson hypothesized that this perception was maintained in spite of the inherent historically established divisions of labour that emerged due to increasing specialisation of roles and fragmentation of knowledge during the 20th century.

Indeed, where interpersonal relationships between professions were discussed in the literature, they were often portrayed in a negative capacity, suggesting that there was limited success in achieving positive relations. Some of the barriers to achieving these were reported as differences in professional socialisation and identity, role conflict, mistrust, lack of clear objectives for the team and lack of organisational support (Barr et al 1999, Hudson 2002, Irvine 2002, Xyrichis and Lowton 2008, Cameron 2011).

The resultant negativity these barriers created contributed to substantial evidence of pessimism in relation to the development of interprofessional collaboration, although a more optimistic perspective was also offered by some studies with collaboration demonstrated as present within services and suggested to be effective. Characteristics that were identified as contributing to this included mutual respect and trust, flexibility, good communication, which, along with professional socialisation, enabled

professional differences to be overcome by groups of individuals working collectively (Hudson 2002).

This perspective was supported by the findings of an exploratory research study by Nancarrow (2004) which offered some similarities to that reported in this thesis. Her study also utilised semi-structured interviews to explore the experiences of individual role boundaries of participants working within intermediate care settings, recognising the value of integrated working and cohesion between individuals when doing so.

Positively, the findings in Nancarrow's study identified close working relationships and role overlap between therapy professions within the team, but, in contrast to this, noted that nursing staff allied themselves to more of a medical model with occasional disagreements occurring between professionals (Nancarrow 2004). When these did occur, Nancarrow identified that participants reported that they were able to be overcome through listening to others and through an increased awareness of their own and other's roles (Nancarrow 2004).

This offered assurance that even if disagreements did arise within services, this did not necessarily derail interprofessional collaboration between individuals who had attained this stage of professional development.

This study by Nancarrow and also a later systematic literature review by Rout et al (2010) provided the impetus in determining the topic to explore within the study reported in this thesis. Rout et al focused on interprofessional collaboration in the field of intermediate care, reviewing research published between the years of 2000 to 2006. This review was significant in highlighting that there was no published research article, at the time of its publication, that either focused on the interactions within intermediate care, to develop interprofessional practice or on "the interprofessional focus of intermediate care" (Rout et al 2010, p. 782).

The findings of Rout's review recognised previous studies had emphasised the quantitative outcomes of intermediate care provision, a conclusion also reached independently by myself. In addition to the lack of emphasis on interpersonal components, Rout also highlighted that, in spite of the intent of this type of service to improve the provision of interventions outside of a hospital environment, there was still "a lack of evidence to support intermediate care", offering further assurance of an opportunity to enhance the existing knowledge base further through this research.

Based on the available literature at the commencement of this study interprofessional collaboration, and intermediate care itself, may therefore be perceived to be viewed pessimistically (Hudson 2002) and with scope for improvement to meet the demand and the legislative political drivers that services were expected to respond to.

These drivers, in the form of UK health and social care policies, were significant in number and published from the latter end of the 20th Century onwards. Based on their content it may be concluded that their aim was to improve the quality of care provided and increase efficiency of performance, requiring organisations to re-design their practices and processes in doing so. However, based on the preliminary literature review, evidence of their effectiveness in achieving these outcomes is elusive, with the observation that, within their content, limited consideration appears to have been given to how these changes affected the staff involved who were required to change their practice to work in a more integrated way (Irvine et al 2002).

Changes to the notion of what constitutes a "professional" has therefore continued as services are reviewed and are re-designed, often requiring practitioners to work differently to the way assimilated as part of their occupational and professional socialisation. To gain an appreciation of how this has evolved an overview of the development of the concept of the

professional will now be provided, offering the background to its historical emergence.

2.5 The historical development of professionals

In their paper, which focused on deconstructing collaborative practice, Thistlethwaite, Jackson and Moran, (2013, p. 52), suggest the word “collaboration” as originating from Latin and indicating “Working with the enemy, working with each other, working together”. Even though many empirical studies have suggested the presence of conflict within and between service providers, collaborative practice, is today, still considered an aspiration for professional practice in contemporary health and social care services. It may also be maintained that the notion of working with friend or foe is still a relevant definition, based on some of the responses obtained from the participants in this study!

Whilst the concept of professionalism developed during the 19th century (Abbott, 1988), the historical background to this can be construed as commencing with the establishment of craft guilds in the 16th century (Reeves, Macmillan and Van Soeren 2010, Green 2014). Similar to modern day professional regulatory bodies, these guilds managed the access to the cognitive and practical tools required to become an endorsed member of a particular profession.

2.5.1 Shaping the professional

The acceptance into certain professions still continues to be restricted today through a regulatory framework. Abbott (1988) and Green (2014) report that entry can only be obtained through the attendance of specific training, the possession of specialist knowledge and adoption of a code of ethics, thereby encouraging participation to be compounded by exclusivity rules that prevent access to those who do not meet the criteria for admission as members (Abbott 1988).

The impact of this is that, historically, each profession has developed separately, claiming a body of “core knowledge” unique to themselves (D’Amour and Oandasan 2009, p. 9), sometimes without seemingly recognising the extent of overlap between themselves and other professions (Irvine et al 2002). However, the legislative drivers at the end of the 20th century to promote collaborative working has necessitated a review of these uni-professional practices by advocating for a breakdown of professional boundaries to promote greater collaboration and integration between professions and organisations (D’Amour and Oandasan 2009) to improve service provision.

Although expectation has been placed on operational staff to achieve this, it may be argued that due to the requirements of their professional and regulatory bodies, (Thistlethwaite, Jackson and Moran, 2013), these practitioners have to overcome the obstacle of maintaining accountability of practice to these, whilst working in as holistic a way as possible, across traditional professional boundaries, to provide their clinical interventions, as required by their organisations.

To work collaboratively across professions in a way expected by legislative frameworks is considered by Sheehan et al (2007) to create a challenge for those socialised into their specific profession’s cultures. This is defined by Hall (2005, p. 188) as “the social heritage of a community” comprising “values, beliefs, attitudes, customs and behaviours” that are shared between the members of the profession.

The development of professional roles has therefore been perceived to rely on social interactions between individuals, from different professions, to form the baseline for collaborative working. This enables staff to be equipped with skills to work jointly with colleagues, whilst respecting their values and beliefs in the process (WHO 2010), to create cohesive interpersonal relationships and enhance integrated working.

2.5.2 Emergence of the interprofessional team

Sheehan, Robertson and Ormond (2007) suggest that within health care since the 1960s there has been an emphasis placed on the development of team work. The lack of consistency in how this development has taken place has resulted in a range of terminology related to team oriented models with diverse conceptualisation of the phenomenon of interprofessional collaboration (D'Amour et al 2005), along a spectrum of practice.

Whilst, the terms multi and inter, (either disciplinary or professional) are often used interchangeably within literature and refer to different types of teams (Leathard 2003, Faulkner Schofield and Amodeo 1999, Scholes and Vaughan 2002, D'Amour et al 2005, Xychris and Lowton 2008, Nancarrow 2013 et al), more recently the prefix transdisciplinary or transprofessional has also been added. This has contributed to further confusion in attributing meaning to the concept of collaborative practice.

To seek clarity in relation to these, from perusal of the literature, multi-disciplinary practice was perceived to relate to a group of practitioners working alongside each other, but remaining within their independent professional groupings when contributing to the episode of care (Scholes and Vaughan 2002, Sheehan, Robertson and Ormond 2007, Bihari Axelsson and Axelsson 2009).

Interprofessional collaboration, in contrast, was perceived to be indicative of a more integrated range of interactions and practice, putting professional paradigms and identities to one side (Soothill, Mackay and Webb 1995, Sheehan, Robertson and Ormond 2007). This implied a willingness to work across traditional professional boundaries.

The addition to the literature of the term trans-professional has not eased the situation as it occasionally appears to be used interchangeably with interprofessional. However, the main difference evident was that whilst

the former term has also been applied within services working across traditional boundaries, there was the recognition of the enhancement of a greater sharing of knowledge, skills and competencies in the latter (Sheehan, Robertson and Ormond 2007). The goal of trans-professional practice has therefore been identified as the attainment of integrated, unified practice (Webster 2002), with a high degree of collaboration.

As the participants within this study all belonged to defined health professions, regulated by codes of professional conduct, the phrase interprofessional was determined to be appropriate to use within this study. This was in contrast to the broader term of interdisciplinary which is indicative of ALL colleagues, irrespective of their occupational role (Nancarrow et al 2013)

Although the paragraphs above offer an elementary synopsis of differences between the different terminologies, it is recognised that due to the existence of the different author's subjective realities, within the literature, these team models are defined imprecisely and may resonate differently in different contexts. This reinforces that, historically, this variability of terminology has led to a lack of consistency of application within the field of interprofessional collaboration.

In support of this perception, the situation was reported in 2011 by Reeves as still not resolved due to the lack of a uniform definition of interprofessional collaboration and multiple perspectives, impacting on the evidence base. To add to the ambiguity further, the different models were also noted to be prominent at different times, depending on the political rhetoric of the era.

Like Reeves, Nancarrow et al (2013) also reinforced the effect of the absence of a uniform definition and the different terminologies used to describe the relationships between the professionals involved. She supported the need to set aside the sub cultures assimilated as a result of

professional socialisation to enable clinicians to work across professional boundaries.

However, realistically to do so, would require the demonstration of trust and respect of colleagues, leading to the development of a more equitable horizontal structure (Greenwell 1995). It was considered that this would enhance the understanding between professionals of their roles and responsibilities (Mickan and Rodger 2005, Day 2006, Centre of Workforce Intelligence 2013) and also offer greater recognition of areas of overlap and similarities between them whilst working towards a shared goal.

It is therefore contended that collaboration does not just automatically occur, instead requiring the proactive implementation of social processes, clarification of roles and responsibilities and negotiation through transparent lines of communication (Thistlethwaite, Jackson and Moran 2013). This helps to ensure that there are clear parameters for how the different members of the team will work together, taking into consideration the diversity of skills and paradigms (Robinson and Cottrell 2005) of the different professions.

To assist with this, confirmation of expected behaviours can help in the development of core values of being interprofessional, which Hammick et al (2009) notes as comprising respect, confidence in the knowledge of yourself and others, a willingness to work with others, approachability and a caring attitude to those with whom you work.

In order to develop these, there does need to be the recognition that for professions to progress to these stages, it may require professionals to work differently. To develop equity of provision in this way would require interaction and negotiation and contrasts with the historical provision previously noted, whereby individual professions had developed separately, some with greater authority and status attributed to them than others.

In spite of the political rhetoric promoting these different ways of working, there is therefore still a lack of evidence to suggest that the introduction of integrated structures leads to service improvement and to effective interprofessional practice (Mickan and Rodger 2005, Sheehan 2007, The Centre for Workforce Intelligence 2013).

The legislative framework of political policy drivers in relation to collaboration have been noted above and have led to the introduction of changes within services which ultimately have altered the ways of working expected of those employed within health and social care practice. This framework will now be explored further.

2.6 Political drivers encouraging collaboration

Xyrchis and Lowton (2008) comment that as far back as 1920 the then Ministry of Health recommended that the provision of community health care would best be met through teams working in primary care. The post war period, however, was characterised by service delivery at a uni-professional level with some pockets of integrated practice (Pollard, Sellman and Senior 2005).

More recently, the WHO (2010, p. 7) has also presented a vision for interprofessional collaboration in education and practice settings suggesting that this would be a desirable state as it “strengthens health systems and improves health outcomes” through the process of staff from different professions working together.

Therefore, nearly 100 years after the Ministry of Health’s original recommendation, integrated practice is a philosophy that it is suggested has not yet been achieved fully. It is still being pursued, with the Centre for Workforce Intelligence (2013) advocating for this by encouraging policymakers to recognise the need for better co-ordinated services to meet the needs of health service users.

In order to meet the challenge of developing greater integrated working, numerous government policies may be perceived as drivers towards collaborative practice. It is accepted though that, on their own, they are not sufficient to achieve this (Barrett and Keeping 2005).

The intent of the legislative framework within the UK was to develop innovative ideas for workforce re-design across professional boundaries, encouraging flexibility in working, whilst also improving performance quality and maximising resources to achieve value for money (Irvine et al 2002, Mickan and Rodger 2005, Cameron 2011). However, Gittel (2008) recognised that in doing so this not only placed pressure on organisations to reduce costs, but also contributed to increased levels of stress for the staff who were expected to work differently to achieve this. Tensions may therefore be perceived to proliferate between the role of the commissioners and the health and social care organisations, but also between the strategic managers and the operational staff in relation to the implementation of policies (Hoyle 2014) and changes to services.

When considering the provision of clinical interventions through this process, there is also the appreciation of an increasing complexity of the needs, within contemporary services, of the service users. As a result, it is suggested that it is not possible for these to be met comprehensively by one provider or profession (Freeth 2001, Irvine 2002, Hall 2005, Wackerhausen 2009, Reeves, MacMillan and Van Soeren 2010), thereby reinforcing the need for the development of integrated practices.

A recent emphasis placed legislatively on the interpersonal element of how individuals work together, was in contrast to the more performance focused earlier Modernization Agenda. This had made the assumption that integrated partnership working across professional boundaries would energise people and would lead to a more innovative and effective use of resources as well as improving the quality of patient care through improved clinical governance and value for money (Freeth 2001, Hudson

2002, Irvine et al 2002, Bainbridge et al 2010, Cameron 2011). Taylor and Kelly (2006) highlight that prior to the 1980s professionals were able to interpret policies using their own discretion and that their professional expertise went largely unchallenged. However, there has been greater emphasis, within policies over the last forty years, in making professionals more accountable for their actions through the introduction of a "plethora of controls and audits" (Taylor and Kelly 2006, p. 632).

Although Masterson (2001, p. 334) had previously evidenced that there was limited cross boundary working between professionals to achieve the requirements of the policies, the pressures placed upon organisations due to the emphasis of the legislative drivers on interprofessional collaboration may be suggested to be a difficult one for practitioners to reject (King and Ross 2004), leaving them with no option but to practice in this way, if they do not already do so.

As a result, those who were in this position, may consider changes to working practices as a challenge, with Hudson (2002) concurring that the move to collaborative practice has not necessarily been perceived positively. He reported the presence of the concept of pessimism to describe the process of attempting to develop collaboration that had taken place between some professional groups.

To demonstrate the presence of interprofessional collaboration within the legislative framework, the following offers a brief synopsis of the political drivers that were key contributors to this. Each offered specific encouragement and expectations in relation to the development of collaborative practice, and enhanced previous policies.

Changes highlighted in "Working for patients" (DH 1989) became legislation in the NHS and Community Care Act (DH 1990), which gave prominence to improved collaboration between professionals and organisations, forming the foundation for modern day community care services by introducing the internal market (Day 2006).

The internal market was subsequently replaced in the White Paper "The New NHS, Modern-Dependable" (DH 1997). This introduced a system of integrated working with the aim of further breaking down organisational and professional barriers, to enable greater joint working between health and social care organisations across defined geographical areas through the introduction of Primary Care Groups (Elston and Holloway 2001). The perception was that interprofessional collaboration and greater integrated care would contribute to achieving this.

Primary Care Groups later developed into Primary Care Trusts and were a forerunner for the existing Clinical Commissioning groups, whose impact on strategic decision making was recognised by many participants within this study as having a significant contribution to the development of their services due to the frequency of re-design requested by them.

Aiming to improve quality standards, performance related measures were introduced in the NHS Plan (DH 2000) and NSF for Older People (DH 2001b). These continued the theme of advocating the benefits of partnership and collaboration between professions in order to improve the outcomes of patient care with the intent to redesign the service around the needs of the patient (Finch 2000). To achieve the required performance outcomes the NSF promoted the development of integrated services within joint commissioning arrangements with the aim of ensuring high quality services for older people (DH 2001b). Standard 3 of the NSF promoted the role of intermediate care within this, setting the scene for collaboration within this type of service.

More recent policy documents including the Health and Social Care Act (DH 2012) and Five Year Forward Review (NHS England 2014) have also placed emphasis on the Integration Agenda and in developing integrated partnership working that was patient focused, requiring the Clinical Commissioning Groups to "promote joined up services" (Centre for Workforce Intelligence 2013, p. 4). To do so would require the

development of new structures and models of practice to break down existing boundaries, as intervention was expected to be more person centred and seamless. This repeated the philosophies documented in previous policies.

Currently the Better Care Fund is the “only mandatory policy to facilitate integration” (DH 2017, p. 5) between public sector bodies, encouraging them to work seamlessly together to ensure a more efficient use of resources. The emphasis within this policy framework was on providing proactive care to maintain individuals within their own home, rather than requiring input from health and social care services.

Recognising the significance of the emphasis within the Better Care Fund to the study of interprofessional collaboration within this thesis, what is of particular relevance are the four metrics it proposes to measure performance by. These are; Delayed transfers of care, Non-elective admissions to hospital, Admissions to residential and care homes and Effectiveness of re-ablement. Section 2.7 will reinforce that these were key components of the original intermediate care criteria advocated by the Department of Health (2001a) and in standard three of the NSF for Older People (DH 2001b). This therefore reinforces the continued significance of intermediate care as a service working within the remit of the UK government’s Integration Agenda.

Whilst earlier documents had encouraged the emergence of integrated practice, there was later recognition of the need to review the training needs of staff to increase their skills to work more flexibly (NHS England 2014), to achieve the requirements of these policies and papers and deliver the new ways of working to support greater integration between health and social care services (Skills for Health 2017). The WHO (2010 p. 7) summarised this suggesting that “A collaborative practice-ready health worker is someone who has learned how to work in an interprofessional team and is competent to do so.” Skills for Health

(2017) reinforced that the Integration Agenda was here to stay and that in order for practitioners to meet the requirements of it, they would need to alter their mindset to work beyond traditional professional boundaries.

Both the Centre for Workforce Intelligence report, and the Skills for Health working paper though, did highlight how working practices could alter in order for professionals to operate more flexibly across professional and organisational boundaries, noting that this may involve changes to existing roles, or the creation of new roles (Centre for Workforce Intelligence 2013), enhancing existing knowledge bases to meet the needs of service users of the future.

Whilst advocating this, they were also realistic enough to recognise that integration and collaboration does not just materialise because policies require them to do so and that consideration needs to be given on how to encourage practitioners from different disciplines to work in an integrated and effective way (Centre for Workforce Intelligence 2013). Through this, it could be construed that there was the recognition of the importance of developing interpersonal relationships in order to meet the demands of the policy requirements.

Furthermore, Hall (2005, p. 194) had suggested that whilst boundaries between different professions were high “they are not insurmountable”, a factor Cameron (2011, p. 53) later supplemented by advising that in order to encourage greater flexibility of working practices this required organisations to take into consideration the “human and social aspects” of this to challenge traditional working patterns. However, this had not always been evident in the government policies published to promote interprofessional collaboration.

Therefore, although emphasis has been placed in concurrent policies on the benefits of working collaboratively to break down barriers between professions, services and organisations (Baxter and Brumfitt 2008), King and Ross (2004) reinforce that there were difficulties and tensions in

operationalising collaborative practice, even with the political drivers in place. In spite of the continued emphasis placed on encouraging integration between organisations, services and practitioners, it may be proposed that barriers and obstacles remain in situ which impact on its progress (Skills for Health 2017).

Based on the documents noted in this section, collaborative working has therefore been portrayed as a mandatory requirement within contemporary health care services. Resources and competencies are encouraged to be shared, with the expectation of positive outcomes for intervention, and the re-positioning of teams along the spectrum from fragmentation towards integration.

Underlying this, Irvine et al (2002) note that with the increase in commodification of health care services, there has been greater expectation from service providers to promote the best use of resources and ensure value for money (Hoyle 2014), due to what the NHS England's Five Year Forward document describes as a "mismatch" between demand and capacity (2014, p. 5). As a result, traditional roles and boundaries have been challenged (Freeth 2001) to meet this disparity and strive to achieve an increase in performance with limited additional resources. To achieve this there has been an expectation of the need to introduce different ways of working at both organisational and operational levels to "help shape behaviours, actions and practices in the workplace" (Hoyle 2014, p. 194).

Interprofessional collaboration therefore tests the stability of well-established professions. It requires staff to work flexibly and to develop new, or adapt existing skills to ensure that they have the competencies to work in different ways required by their service, with the core of the team comprising generically trained staff, supported by a small number of people in more specialist roles (Primary Care Workforce Commission, 2015).

2.7 Development of intermediate care

Reviewing the early literature in relation to intermediate care services, the way of working, noted above, was expected of clinicians employed within them, with a greater emphasis placed on flexible practices, transcending professional boundaries to undertake integrated working (Pearson et al 2015). In addition, there was also a greater expectation of closer partnership working between health and social care services. Realistically though, integration between organisations does not always readily equate to integrated practice at an operational level.

In spite of this, the requirement to work collaboratively within intermediate care services reinforced the relevance of this type of service to seek out sufficiently rich qualitative data to respond to the research questions of the study. Within this section a historical overview of the emergence of intermediate care and clarification of the criteria for patients to be accepted onto the service, is provided to support the rationale for this.

The intermediate tier comprises networks of services whose remit is to address the functional needs of individuals who have experienced a sudden and acute deterioration in their medical or psychological condition, through supporting them either in their own home or in community based residential facilities in contrast to an acute hospital environment. Service users referred to intermediate care are therefore expected to be medically stable or medically predictable, as interventions are provided to help them to adapt to a change in their functional status (DH 2009, Young et al 2015) through programmes of rehabilitation.

Intermediate care services were therefore developed, not as a substitute for admission to an acute hospital bed, but as an alternative for those who did not need this type of intervention (Young and Stevenson 2006, Glasby et al 2008, Thomas and Lambert 2008). A referral to an intermediate care service would involve a comprehensive assessment of

need, would involve cross professional working using shared documentation, practices and protocols and would usually be provided on a short-term basis (DH 2001a).

To supplement existing health and social care provision, intermediate care services developed in response to demands faced by acute hospitals which were highlighted in the findings of the National Beds Inquiry, reported in *Shaping the Future NHS* (2000). This indicated the extent of pressures within the hospital sector, documenting that the health and social care systems of the time were not meeting the needs of older people. It reported that two thirds of general and acute hospital beds were occupied by people aged 65 and older, who, as a result of taking longer to recuperate from their illness, were perceived to contribute to pressures on services through, what was termed "bed blocking".

The inquiry found that had alternative community based services been available, approximately 20% of acute bed days could have been saved for the population surveyed (Martin et al 2007). There was therefore an expectation that the provision of these additional services would lead to cost savings and an improved flow of patients from admission to discharge. As a result, the development of intermediate care services was promoted to shift the emphasis away from acute hospital admission to those who met the criteria for these new types of services.

To assist with determining how these services operated, criteria were developed highlighting the provision of intermediate care services as being to maintain people in their own home through preventing unnecessary hospital admission, facilitating early discharge from hospital and reducing the need for long term residential care (DH 2001a, DH 2001b, Stevenson and Spencer 2002, Thomas and Lambert 2008, DH 2009, McClimens et al 2010, Young et al 2015).

However, in spite of the publication of these criteria there was a lack of consistency in how intermediate care services developed (Grant et al

2007), with them evolving in different ways in different areas. An effect of this is that due to this diversity and complexity of intermediate care services, measuring the effectiveness of them has proved to be problematic (Martin et al 2007, Thomas and Lambert 2008). The lack of prescribed consistency in how intermediate services operate has, though, allowed them to develop in different ways, across a regional and local context, dependent upon the needs of the population within those areas. This reinforces Nancarrow (2004, p. 143), who suggested that a “typical” intermediate care team is unlikely.

Intermediate care services were considered to act as a middle tier of provision, being positioned to operate seamlessly between acute hospital and primary care settings (Young et al 2015), as well as social care, private and voluntary sectors and providing an alternative to hospital admission (Moore et al 2007).

Whilst cost savings within acute hospitals were an impetus for the development of these services, a subsequent DH report (2002), suggested that they could also assist in improving the quality of care for those using these types of services, by relying on the implementation of co-ordinated, joint working between health and social care, with an emphasis on improved integrated working.

The shared assessment framework, generic competencies and shared roles within these types of services therefore reinforced them as relevant within which to explore interprofessional collaboration.

2.8 Summary

This chapter has provided a historical overview of the emergence of interprofessional collaboration and how it has been constructed over the decades, with political drivers placing a great deal of emphasis and expectation on staff to work differently. It has reviewed the literature available at the start of this study, recognising the gaps in this and in

particular the limited number of studies that have investigated the concept of interprofessional collaboration within intermediate care settings.

Within this chapter there has also been the recognition of the lack of consistency in terminology and definitions used within the context of interprofessional collaboration which has led to ambiguity of meanings and has impacted on the development of the interprofessional arena of knowledge. To overcome this, within this study, a definition of interprofessional collaboration has been offered to provide clarity of understanding of the author.

This chapter has therefore situated the knowledge available upon which the study was based, exploring the experiences of participants working collaboratively within intermediate care settings. The following chapter will complement this foundation by providing insight into the methodology determined as most appropriate to undertake this study in order to contribute to further enhancement of the existing knowledge base.

Chapter 3 – Methodology

Introduction

The previous chapter explored the preliminary literature review of the phenomenon of interprofessional collaboration within the context of intermediate care settings. It confirms the existence of a gap in research relating to the exploration of the interpersonal relationships and social processes which contribute to the creation of collaborative working and how it is sustained. This chapter will provide the justification for why the methodological approach of Constructivist Grounded Theory was chosen as being most appropriate for use to investigate this further in this study.

From its foundation in the 1960s there has been an evolution of Grounded Theory, with divergence from the original version. A historical overview of this and comparisons between the different variations will be offered as part of this discussion. In doing so consideration to the role of Symbolic Interactionism, as theoretical perspective, in informing the study will also be undertaken. This reinforces why the emphasis on the construction of subjective interpretations of reality, through interactions with others, is relevant for this study.

Recognising the integral role of the researcher when undertaking the study, reflexivity has been exercised throughout to provide transparency of the decision-making process in determining the methodology, taking into consideration my own philosophical stance which subsequently influenced the ontological and epistemological perspectives.

3.1 Determining the methodology

Nicholls (2009a, p. 589), suggested that “methodologies provide a particular lens through which we may approach the questions posed by our desire to understand the nature of reality”, with them being “a set of principles and ideas that inform the design of the research study” (Birks and Mills 2011, p. 4). The significance of this is that they require strategic decisions to be made by the researcher to determine the most

appropriate approaches to obtain pertinent information about the social world under investigation (Walsh and Wiggins 2003, Denscombe 2008, Denzin and Lincoln 2005).

Creswell (2007) and Birks and Mills (2011) reinforce that in doing so, any research is guided by a researcher's ontological and epistemological assumptions; with their beliefs, paradigms and feelings about the social world and how knowledge is attained influencing the choice of methodology and methods (Crotty 2005, Mills, Bonner and Francis 2006b, Polit and Beck 2010).

The impact of this is that two researchers will approach the same phenomenon from their own individual perspectives and preferences. For the purposes of investigating the social worlds of the participants in relation to interprofessional collaboration, the assumptions within this study are conducive with a relativist ontology, that reality is subjective, socially created by individuals and contextually specific to each team, individual or event they encounter.

In determining this there was recognition that the individual perspectives of the participants would comprise several versions of reality, equally relevant in terms of representing the "truth" about particular phenomena (Andrews 2012, p, 2).

Considering the available methodologies, historically there has long been the suggestion that qualitative research lacks "scientific rigour and credibility" (Horbsurgh 2003, p. 308). Despite this, a qualitative methodology was determined to be the most appropriate for the purposes of this study. This decision was made based on the awareness that qualitative methodology involves the interpretation of the "constituent properties of an entity" (Smith 2008, p. 1), hence its relevance in obtaining data to explore the meanings that individuals apply to their experiences within intermediate care settings.

This contrasts with how quantitative analyses emphasise measurement to ascertain “how much of the entity there was” (Smith 2008, p. 1). Whilst this is indicative of many previous empirical studies of intermediate care services relating to the performance indicators and outcomes of intervention, such an approach was disregarded, within this study, as methodologically limiting and insufficient to meet the research aims.

A qualitative approach, therefore, enabled the exploration and analysis of the in depth personal information required to generate understanding of individual experiences as people disclosed their unique versions of reality. Utilising this approach, exploration of the topic takes place and insight is gained through interpretation of the events, as perceived by the participants, in order to generate understanding (Gray 2014). This was relevant within this study as interpretation and generation of meaning occurred during the course of semi-structured interviews, subsequent analysis and comparison of data and continued up to and including the writing up stage.

In summary the methodology for this study was chosen based on a relativist ontology; the personal belief that society comprises multiple realities that are socially constructed on an individual basis. The following section will demonstrate why the Constructivist paradigm is most appropriate for use within this study due to its relevance in exploring phenomenon relating to personal accounts and interpretation of meaning.

3.1.1 A Constructivist paradigm

When reviewing the literature it was noted that the labels “Constructivist” and “Interpretivist” were used interchangeably (Robson 2002), dependent on the author, with both labels emphasising individuals making sense of meanings. For the purposes of this thesis the term Constructivist is the preferred one for continuity purposes.

As Constructivism is an ontological perspective and also an epistemological position that recognises that two people's personal accounts of the same event will differ, this approach enabled insight to be gained of the individual participant's perceptions of their experiences. The reality explored during data collection was subjective, and constructed on an individual basis by each person, including myself, immersed in the process (Robson 2002, Darlaston-Jones 2007, Charmaz 2014). In doing so this requires the researcher to be aware of their own presuppositions to avoid these affecting the constructions and a reflective diary was kept to review these, within the context of this study.

From the perspective of a researcher the methodological framework affects the position taken in relation to positioning oneself with the participants, whether to remain at a distance or to be inclusive (Birks and Mills 2011). Following the principles of co-construction within a Constructivist Grounded Theory approach, and recognising that "total detachment on the part of the researcher is unattainable" (Horsburgh 2003, p. 308), a stance of active inclusion was undertaken, with the outcome of the study co-constructed between the participants and myself, enabled by the interaction that took place during the interview process.

This positioned the researcher as not "neutral" within the study, acknowledging my input and taking into account the prior knowledge and experience and also the role I played in undertaking the research (Mills, Bonner and Francis 2006a). Due to the phenomenon under investigation, this approach was therefore deemed particularly pertinent for an exploration of interpersonal relationships.

Unlike a positivist approach which is characterised by the testing of hypothesis through objective measurement of the social world external to the individuals involved in it (Darlaston-Jones 2007), within a Constructivist approach, theory is inductively developed taking into

consideration that meaning is socially constructed and moulded by previous experiences, norms, values and beliefs (Charmaz 2014).

Given that a positivist approach emphasises an independent, objective reality, has an alignment to the natural sciences, deductive reasoning and the testing of variables to establish relationships between them, this approach would not have fully represented the dynamic nature of interpersonal interactions between the participants within this study. Neither would it have fully explored the social processes pertaining to how the experiences and diversity of perspectives of the participants were socially created.

Instead, from an alternative perspective to inquiry, the Constructivist approach places emphasis on understanding as opposed to explanation (Charmaz 2011), discovering patterns rather than linear reasoning and recognising the individualised nature of these processes, that they are a product of social construction (Robson 2002) unique to that time, place and person. The application of this led to the identification of a “reality” that was a co-constructed interpretation in contrast to definitive “facts”.

To summarise the processes undertaken for reasoning the methodology, the following diagram is adapted from Carter and Little (2007, p. 1317). It reflects the ontological and epistemological assumptions utilised within this study, offering a pathway for how decisions taken in relation to the study design ultimately led to the development of knowledge.

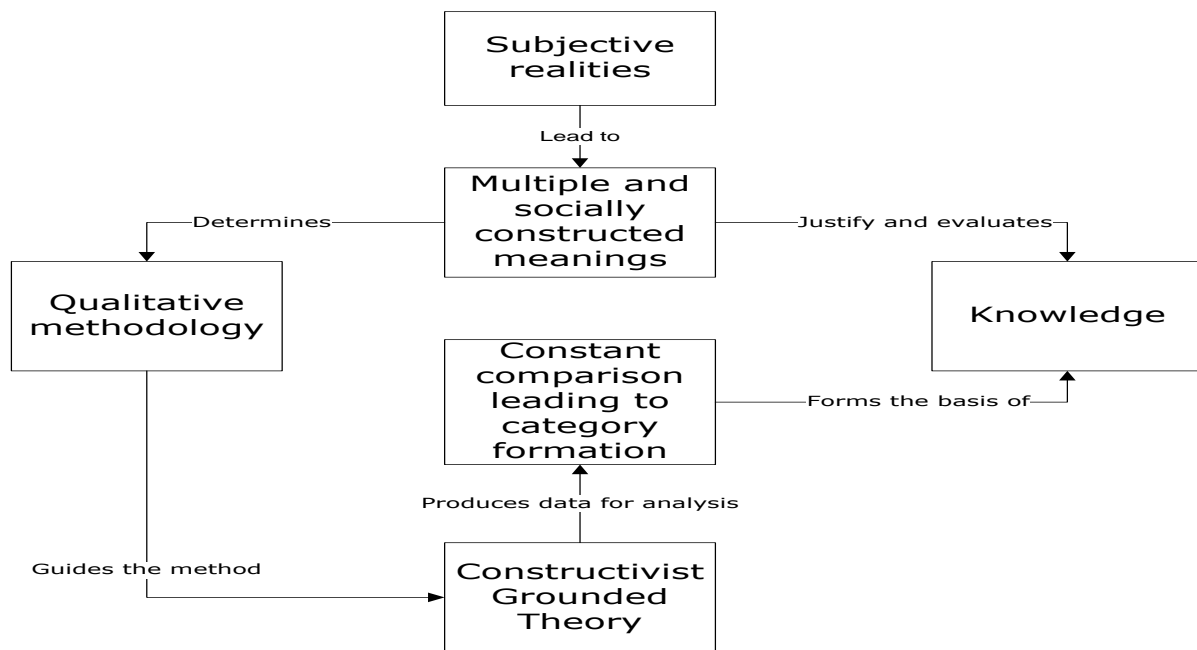


Figure 1 Methodological decision making within this study

The following sections will explain in more detail how these assumptions were rationalised and subsequently operationalised to undertake the study.

3.2 Considering the theoretical perspective

Crotty (2005, p. 8) suggests theoretical perspectives are a “way of looking at the world and making sense of it”. This section will now provide insight into the theoretical perspective used in this study.

The purpose of the study was to explore the diverse realities of the participants working within the context of intermediate care settings, in particular in relation to their interactions with each other and their surroundings. This recognition led to further exploration of the theoretical perspective of Symbolic Interactionism which had evolved from the tradition of pragmatism; focusing on multiple realities and, on how people apply and construct meanings to events, actions and interactions fluidly and the “symbols they use to convey that meaning” (Baker, Wuest and Noerger 1992, p. 1356).

Individuals use these meanings to interpret and offer an explanation for how people interact in society. This leads to the development of shared understandings through the process of interpretation (Sheehan, Robertson and Ormond 2007).

Rather than considering people as passive participants, Symbolic Interactionism instead supports and explores the dynamic, active interpretations that take place between individuals in society, constructing and reconstructing a flexible reality on micro, meso and macro levels (Charmaz 2014). These rely upon interaction between individuals to achieve this. This was therefore pertinent for use in this study as participants did not curtail their responses to reflecting just on their interactions with their immediate colleagues but also in relation to their service and organisational elements.

3.2.1 Background to Symbolic Interactionism

Symbolic Interactionism is a sociological and social psychological perspective, with Blumer (1969, p. 1), describing it as an approach to the “study of human group life and human conduct”. It is somewhat ironic that he suggested that he had only devised the term Symbolic Interactionism for the purposes of a 1937 article, with it subsequently becoming an adopted label. This perspective is particularly valuable in that the phenomenon may be explored from the position of either the group or individual, as in the case of this study. It recognises how they construct meaning as a dynamic process of interaction in different contexts.

This is reinforced by Charmaz (2014) who noted that within Symbolic Interactionism individuals respond dynamically to situations to “create, enact and change meanings and actions” (Charmaz 2014, p. 9).

Although Blumer’s version of Symbolic Interactionism will be reported on in this thesis, it is not solely his creation. He credits a number of scholars

with contributing to the evolution of it and particularly singles out George Herbert Mead as providing the baseline for the foundation of his own work (Blumer 1969).

Blumer (1969, p.2) developed three premises which form the basis of Symbolic Interactionism:

1. "human beings act towards things on the basis of the meanings that things have for them."
2. "the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows."
3. "these meanings are handled in and modified through, an interpretative process used by the person in dealing with the things he encounters."

These premises were later supplemented by Charmaz (2014), who proposed that it was the combination of shared language and communication that processes the interpretation of meaning. She reinforced that this interpretation only becomes explicit when problems arise with it.

To enable understanding of actions and behaviours, Symbolic Interactionism therefore focuses on the relationship between individuals and their environments considering them to be active participants in creating meaning and order in society.

It is the dynamic nature of these interactions and the meanings applied to them through social processes, on a subjective basis, which this study intended to explore at the outset, to determine how the participants interact and why interprofessional collaboration existed more successfully in some services than in others.

Section 3.2 has offered a perspective as to why Symbolic Interactionism was used as a foundation for this study reinforced by the intent to explore

and ascertain the meaning behind the participants understanding of their experiences of working in a collaborative way, but also the fact that, in accordance with a Grounded Theory approach, it may be utilised with an individual or groups of individuals (Baker, Wuest and Noerger 1992) to offer insight into the processes that they action.

A number of commentators suggested that Grounded Theory is underpinned by the principles of Symbolic Interactionism, investigating how individuals generate symbolic meaning during their reflexive interactions with others (Goulding 1999, Cutcliffe 2000, Finlay and Ballinger 2006, Corbin and Strauss 2015, Denscombe 2008, Nicholls 2009, Miliken and Schreiber 2012, Handberg et al 2015) and construct realities and meaning based on past and current interactions and interpretations.

A historical perspective of the evolution of Grounded Theory, from which this emerged, will now be considered, highlighting the adaptation of the different versions and the rationale for why, ultimately, Constructivist Grounded Theory was applied within this study.

3.3 The development of Grounded Theory

Recognising the historical development of Grounded Theory, further exploration of the literature was required to ascertain which would be the most pertinent version to use within this study to achieve the research aims. In doing so consideration was given to the fact that, whilst all versions comprised commonalities in some characteristics and processes, developmental divergence had taken place which had modified them from the original Glaser and Strauss version, each of them facing challenge from Glaser (1992, 2012) in doing so.

Glaser and Strauss developed Grounded Theory in the 1960s to assist in the analysis of, what was initially, Strauss's research study into the experiences of patients who were dying in hospital (Baker, Wuest and

Noerager 1992, Boychuk Duchscher and Morgan 2004, Birks and Mills 2011, Corbin and Strauss 2015). Literature records that, in developing this, Glaser was influenced by the positivist perspective and quantitative methodology of Columbia University (Glaser 1992, Charmaz 2014), whilst Strauss continued his work in qualitative methodology at the University of Chicago (Glaser 1992, Corbin and Strauss 2015).

Within the era of research that Grounded Theory originated, qualitative approaches were considered to be of a lesser status than quantitative (Glaser and Strauss 1967, Coyne 1997, Denzin and Lincoln 2005, Charmaz 2012), with an emphasis placed on verifying rather than generating theory (Glaser 1978). Therefore, as a response to the more accepted empirical approaches (Suddaby 2006), Glaser and Strauss published their innovative methodology in their seminal book "The Discovery of Grounded Theory" (Glaser and Strauss 1967, Holton 2008). This outlined the processes by which theory may be generated within a qualitative paradigm, developing a methodology emphasising process, action and meaning.

3.3.1 Development of theory

Recognising that whilst variations of the original Grounded Theory philosophy and methods have emerged over the last 50 years, what has remained consistent is the underlying purpose of developing theory from data, and specifically, in the case of Grounded Theory, from data relating to human interactions (Hall, Griffiths and McKenna 2013, Handberg et al 2015), as was the case in this study.

Originally it was suggested that any epistemological perspective or ontological stance may be adopted by a researcher using Grounded Theory (Breckenridge 2012) dependent upon the study being undertaken.

This flexibility in approach was supported by Glaser (1978, 1992), Denscombe (2008), and Corbin and Strauss (2015), suggesting that a

multitude of data collection methods may be used. Furthermore, Morse (2009) suggested that every time Grounded Theory is used it requires adaptation in order to meet the requirements of the study, rather than being restricted to a prescriptive process (Charmaz 2014). The usefulness of this approach within this study therefore encouraged flexibility and allowed processes to be adapted, following trial, to ones that were more pertinent to obtain relevant data with which to answer the research questions.

The aim of Grounded Theory is to ascertain a conceptual framework for the situation under investigation, leading to the discovery of theory (Glaser and Strauss 1967, Glaser 1978, Glaser 1992). It follows an iterative process of memo writing, constant comparison and theoretical sampling, iterative data collection and the analysis of processes and actions to develop concepts and categories. This leads to the identification of core category (ies) and subsequently the construction of theory (Glaser 1992, Mills, Bonner and Francis 2006b, Charmaz 2011, Kelle 2007).

Grounded Theory is particularly useful where the aims of the study are to learn about individual's experiences of a particular social situation (Suddaby 2006) and to investigate the "key social, psychological and structural processes that occur in a social setting" (Polit and Beck 2010, p. 72), hence its relevance within this study to explore the multitude of experiences of the participants within the specific setting of intermediate care services.

In order to substantiate the findings, the theory that emerges from Grounded Theory studies are grounded in the data (Glaser and Strauss 1967), with the characteristics noted above maintained irrespective of the version used. Whilst there is an emphasis, in the earlier versions of Grounded Theory, on conceptualisation, evolution of the approach has led to a greater emphasis on interpretation, thereby altering the proximity of the researcher to the data, as noted earlier.

3.3.2 Divergence of thinking

A divergence of thinking between the two original founders resulted in Glaser and Strauss developing the approach in different directions in the 1980s (Bryant and Charmaz 2011, Hall, Griffiths and McKenna 2013). This was described in, what I considered to be, somewhat scathing terms by Glaser (1992) in his text, he documented that he had written especially with the intent to highlight, how he considered that Strauss and Corbin had deviated so significantly from the original version. Whilst Strauss had linked with Corbin to develop, what became termed Straussian Grounded Theory (Higginbottom and Lauridsen 2012), Glaser continued his work on Classic Grounded Theory, challenging others who also suggested modifications to it.

From Glaser's approach, within his many articles in the literature, he may be perceived as protecting "his" version, however it can be construed that he does so despite the fact that he admitted (Glaser 1978) that, along with Strauss, they had previously suggested the approach was available for others to take it in whatever direction they wished.

First though, a brief comparison of the original collaborators' versions and why they were not used in this study.

3.3.3 Comparison of Classic and Straussian Grounded Theory

Recognising Glaser's background in quantitative methodology, the Classic version is rooted ontologically in realism, assuming reality exists objectively, independent of individuals. Charmaz (2011), on the other hand, counters this by suggesting that, rather than objective facts, a contrasting view would be to consider they be treat as constructions. This formed the baseline for the evolution of her version, recognising the value of interpretation within this.

The contrast with the Classic approach is further notable, in that in the Classic version, theory is discovered from the data and verified,

maintaining its objectivity from the researcher (Hall, Griffiths and McKenna 2013). The intent of this was to allow the emergence of theory from the data and, as a result, for it to be “devoid of interpretivism” (Boychuk Duchscher and Morgan 2004, p. 606).

Unlike the phenomenological emphasis on legitimate data being the experiences of the participant, Grounded Theorists can use varying types of data, with Glaser reinforcing this in his well-known comment that “all is data” (Glaser 2012 p. 28). He suggests that this involves anything pertinent to the study, whether that be qualitative, quantitative or a combination of these (Holton 2008). This has relevance within this study as it enabled greater opportunity to collect data through the use of semi-structured interviews as well as visual imagery tools. In addition, field notes were also documented following completion of each interview, thereby offering a record of my own interpretation of each of these.

The participation of the researcher in the study, and their interaction with taking part in it, was another contrast with Glaser’s approach, as he insisted on neutrality and detachment between the researcher and the participants, (Boychuk Duchscher and Morgan 2004, Denscombe 2008, Hall, Griffiths and McKenna 2013). In doing so this did not acknowledge the effect that the previous experiences of the researcher had on a study, or the relationship between researcher and participant.

Glaser suggested instead that the researcher should listen, observe and defer to the participants during the study as they were the ones with the experience and expertise in the phenomenon (Glaser and Holton 2005). He advocated that this enables the researcher to stay sensitive to the data, striving for objectivity in order to prevent any bias, formed from previous perspectives, impacting on the study (Mills, Bonner and Francis 2006b, Hall, Griffith and McKenna 2013).

In contrast, the Straussian version is relativist, suggesting that reality is interpreted subjectively and recognising that the researcher does have an

impact on the study as they search for meaning in the data. By adding procedural steps to the analysis when undertaking coding and immersing oneself in the data, Strauss and Corbin suggests that this assists in understanding the significance of meanings for the participants (Charmaz 2005, Mills, Bonner and Francis 2006b, Hall, Griffiths and McKenna 2013), and provides the opportunity to gain fresh insight into the phenomenon. In response to this both Charmaz (2014) and Glaser (1992) suggest that such a prescriptive approach could constitute “forcing” the data down preconceived routes. Glaser suggests that the approach offered by Strauss and Corbin uses preconception and conjecture to produce conceptual description rather than a Grounded Theory. He attributes the findings to being obtained through a verificational method of forcing data, rather than allowing it to emerge.

The role of the researcher, to contribute to data analysis, evolves further within Constructivist Grounded Theory as they interpret and co-construct the data in conjunction with the participants. Researchers reflect on their own experiences in doing so and develop a relationship of equal status (Mills, Bonner and Francis 2006a). Due to the interaction required between the participants and researcher to explore individual experiences, this was an approach deemed particularly relevant for this study as personal experiences and opinions were shared by the participant and co-constructed by myself.

Taking into consideration the variances between the two originators’ versions of Grounded Theory identified above, neither of them were considered to be an appropriate fit either for my personal ontological or epistemological assumptions. I therefore concluded that I would not adopt either of these. Instead, the later Constructivist version advocated by Charmaz was identified as more convincing to meet the aims of this study. The rationale for selecting this approach will now be identified in the following section.

3.4 Constructivist Grounded Theory

Charmaz developed her version of Grounded Theory in spite of facing challenge from Glaser (2012). She advocated maintaining the core components of the original version's methodology, although she used the procedures flexibly and without the positivist slant that influences some Grounded Theorists (Charmaz 2014). Emphasis was placed on the construction of data and theories, rather than the discovery of them (Charmaz 2005, Hall, Griffiths and McKenna 2013).

In taking the decision to opt for Constructivist Grounded Theory I took into consideration the points highlighted in the previous sections of this chapter and in doing so determined that the emphasis on a flexible approach to methods, multiple realities, reflexivity, along with the central role of the researcher in the data collection, analysis and development of theory encouraged me to consider Constructivist Grounded Theory as the most relevant version to utilise in this study.

3.4.1 Comparing Constructivist Grounded Theory and phenomenology

Whilst demonstrating the rationale for choosing Constructivist Grounded Theory, this section will highlight the similarities between this approach and that of phenomenology and how, at the outset of the study, consideration was also given to the appropriateness of utilising phenomenology to undertake this research. This was compared with other Grounded Theory versions before determining which would be of most relevance within this study.

The aim of phenomenological research is to study the subjective experiences of the participants, to discover the essence of the phenomenon, determining meaning from individuals' lived experiences and report on their interpretation of these experiences as they understand and are able to articulate them (Baker, Wuest and Noerager 1992, Ellis 2002, Creswell 2013)

This approach considers all individuals as operating uniquely with their own world view, (Nicholls 2009), with the intent of obtaining information about their individual interpretations. It deviates from Grounded Theory, within which the researcher is concerned with the interconnections between the individuals and how meaning is ascertained collectively within communities (Nicholls 2009), conceptualising these into theoretical statements about the relationships.

This was an important factor in why phenomenology did not become the methodology of choice, as it was perceived that through the findings of the study and the use of Grounded Theory, there would be an opportunity to develop a relevant theory of collaboration that could be utilised in an intermediate care setting and potentially other contexts too.

Whilst there is recognition that phenomenology shares common characteristics or “method slurring” (Corben 1999 p. 55), with a Grounded Theory approach, there are also some key differences.

Participants within a phenomenological study have experienced the phenomenon in question, and are identified through purposive sampling (Baker, Wuest and Noerager 1992). This is in contrast with theoretical sampling in use in Grounded Theory, whereby the emergent data provides the direction for sampling in subsequent semi-structured interviews as opposed to unstructured ones favoured in phenomenological studies (Mapp 2008).

Whereas Grounded Theory leads to the generation of theory to explain process, action or interaction, Corben (1999) notes that phenomenology uses neither induction nor deduction but instead description. Therefore, unlike Grounded Theory the intent is not to generate theory but to encourage the reader to draw their own conclusions from the narrative provided.

In addition, phenomenology does not utilise the constant comparison method in order to compare data with data, instead making sense of the essential meanings attributed by the participants. These are then used to determine the essence of the phenomenon (Creswell 2007).

Whilst appreciating that there were shared characteristics between phenomenology and Constructivist Grounded Theory (Baker, Wuest and Noerager 1992), due to the emphasis in phenomenology on deriving insight through the description of experiences (Mapp 2008), Constructivist Grounded Theory, with its emphasis on the development of theory to explain the rationale behind how interprofessional collaboration develops was chosen instead for the reasons already highlighted previously.

3.4.2 Constructivist Grounded Theory within this study

Birks and Mills (2011) consider Constructivist Grounded Theory as emerging during the fourth stage of qualitative research, which took place between 1986-95, during which time Charmaz advocated her version (Mills, Bonner and Francis 2006b). She placed greater emphasis on the role of the researcher within the study; their impact on it and on their relationship with the participants, with the lineage traced more from Straussian Grounded Theory than the Classic version.

This section expands on the rationale for why Constructivist Grounded Theory became the approach of choice due to the flexibility in approach to methods, the integral role of the researcher within the study leading to the construction of the findings and theory and the compatibility with ontological and epistemological assumptions for the study that were documented earlier in this chapter.

Coherent with the aims of the study, Constructivist Grounded Theory has a relativist ontology and subjectivist epistemology (Denzin and Lincoln 2005); it interprets meaning through the researcher interacting with others, in order to actively construct an account of reality (Mills, Bonner

and Francis 2006b) within a cultural context. As such the findings are considered to emerge from the data.

This approach provides a suitable fit for this study due to the role undertaken within the semi-structured interviews to develop a relationship with the participants, to seek interpretation of their experiences and co-construct meaning from these, rather than compressing the data into pre-ordained categories.

Recognition is provided here that this process also includes reflexive consideration of the impact of the researcher's own previous experiences and assumptions when constructing this reality (Corbin 2009, Charmaz 2014, Higginbottom and Lauridsen 2014). Through the process of exploring these preconceived values and beliefs which, usually, are running along in the background in our subconscious, researchers build knowledge.

The risk though, is that researchers may inadvertently introduce their own preconceptions into the research, particularly if they are not aware of them, hence researchers are encouraged to be reflexive about what they, as well as the participants, are bringing to the study, (Charmaz 2011). Glaser (2012), highlighted a risk of the researcher forcing the responses of the interviews in a particular way, thereby he expressed concerns about the researcher taking the lead in constructing the interview.

This was especially pertinent during this study with the a priori knowledge I was bringing to it. However, due to the awareness of this possibility, memos and a reflective diary assisted with documenting, and managing this.

Rather than dismissing the role of the researcher, Charmaz (2011, p. 140) recognises their impact in this process, suggesting that "Each theory bears the imprint of its author's interests and ideas and reflects its historical context as well as the historical development of ideas". Not only

does she consider that this strengthens the theory but that this also allows for comparison between studies (Charmaz 2011). It may be implied, from this, that it is therefore not possible to detach the theory from the researcher.

The proximity of the researcher, in this way, contrasts with Glaser's perspective in that it reinforces the concept that rather than the discovery of theory from the data, as in the Classic Grounded Theory version. The conventions of Constructivist Grounded Theory are that the data and theory are actually part of the world that we study.

As researchers are noted to be unable to reproduce an exact replica of the participant's perspective, they therefore produce an interpreted rendition of it (Charmaz 2011, Higginbottom and Lauridsen 2014). The data and analysis comprise social constructions and multiple viewpoints and, in the case of this study, fresh insight into the topic of interprofessional collaboration in the contextual setting of intermediate care within which there has been limited research of this concept.

Whilst following the lineage of Straussian Grounded Theory, Charmaz does not adopt the coding strategies inherent in this, instead utilising flexible guidelines and practices, as opposed to prescriptive methodological practices, with which to raise questions about the data (Charmaz 2014, Kenny, 2014). This characteristic though has been advantageous in this study as review and revision of processes and themes took place as the study progressed. This enabled a less restrictive approach, and allowed the data to emerge more readily than if the coding strategy had been pre-determined at the start of the study.

Glaser suggested that theory should be developed from the data, through the process of constant comparison, to identify latent patterns (Holton 2008, Glaser 2012), aiming for theoretical generalisation rather than interpretive understanding of the participant's meanings.

Continuing his concerns about Constructivist Grounded Theory, Glaser (2012, p. 29) challenges Charmaz's use of "mutually built up interpretations" indicating that this leads to difficulty in characterizing the data. However, Charmaz counters this criticism of her work by advocating that a Constructivist Grounded Theory *is* analytically possible, through maintaining the words of the participants during the process of analysis (Mills, Bonner and Francis 2006b). She suggests that even data that is perceived to be emergent and discovered still requires a degree of interpretation to put reality into context (Mills, Bonner and Francis 2006b). This is of particular relevance within this study as the emergent data was interpreted based on an appreciation of the meaning applied by the participants.

A further variance between the versions is that, unlike the Classic Grounded Theory emphasis on the development of a core category, Constructivist Grounded Theory does not confine itself to the single core category, allowing for more than one, in order to encompass the multiple realities of the participants. Breckenridge (2012), suggests that this has led to a significant deviation from the original versions, noting that the purpose of the core category was to indicate the most highly relevant aspects of the participant's behaviour in the area under study.

Within Constructivist Grounded Theory there is therefore an awareness that multiple realities exist and this was also evident within the findings of this study. However, for the purpose of developing theory one reality has been identified to reflect the co-construction of meaning between the researcher and participants. The following section will now explore how the abstraction of data contributed to the development of theory within this study.

3.5 Induction v deduction v abduction

Within Grounded Theory research the aim is to start with a broad research topic and to inductively develop a theory within the context of it

(Henn, Weinstein and Foad 2009), following an increasingly focused collection and analysis of data. Theory is grounded in the field of study but also utilises existing theory as concepts emerge from the data (McGhee et al 2007) and literature is reviewed.

Grounded Theory commences from the experiences of individuals and the meanings that they attribute to them, making sense of these and devising theoretical perspectives from them (Stanley 2006). Within the study in this thesis different lines of inquiry were determined by the data. Some of these were anticipated, but others were more surprising.

These created analytic concepts which were subsequently investigated further through additional data collection, to support or review them. Glaser (1978), suggests that within a Grounded Theory study deduction is used to seek comparisons for further discovery rather than to derive a hypothesis, leading to the theory initially being based on the emergent data rather than extant literature. These links occur later in the theory generation process.

Whilst a deductive approach involves starting with a theory to use as a baseline to seek data, induction involves progressing from data to theory, with both induction and deduction taking place during the process of abduction in Grounded Theory (Bryman 2012).

This is a view shared with Charmaz (2011, 2014), who suggests that the abductive method, operates in a series of repetitive loops to produce mini hypotheses guiding increasing conceptualization and theorization from the extrapolation of data.

When reflecting on this process, and how this may work in this study, the following diagram was produced to offer an interpretation of the abductive loop undertaken. Rather than abduction as a continuous loop, with no apparent outcome, it may be suggested instead that following the deductive stage the researcher has the option to explore the data further

to create additional hypotheses or react to that already explored, which may include no further investigation and concluding the study.

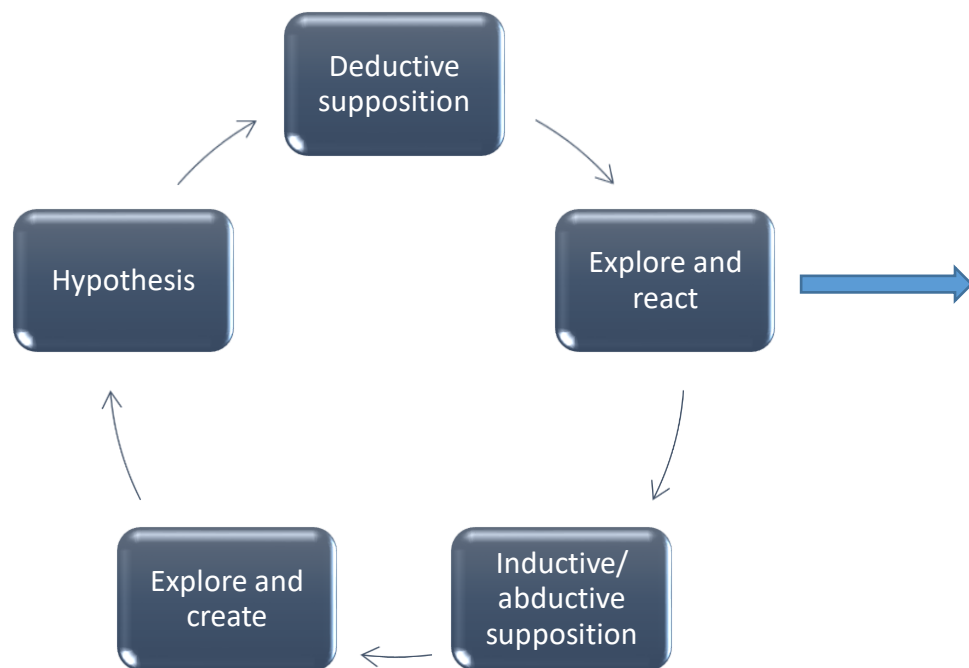


Figure 2 The loop of abduction

Historically, abduction was developed by Peirce in the late 19th century as an alternative to induction and deduction (Locke 2007). He suggested that it was a way of explaining a surprising finding (Charmaz 2014), with inferences or mental leaps required to explain how to account for it.

Given that upon commencement of a study, there is a lack of clarity as to the direction it will take, abductive reasoning is reinforced by Charmaz (2011) as moving towards the formation of hypotheses by discovering and exploring all explanations for the data. This involves making probability statements between concepts that would not normally be associated, forming hypotheses to confirm or disconfirm until the researcher arrives at the most plausible interpretation of the observed data.

In effect it could be described as thinking outside of the box imaginatively, to identify new ways of looking at the phenomenon, a feature in line with the requirement of those undertaking a Doctorate, but

also those facing the task of service re-design to meet the requirements of the legislative drivers.

Whilst abductive reasoning is not a true reflection of a reality, it is therefore an interpretation of it at that particular contextualised point in time, recognising the opportunity for this to be explored further and enhanced at a later date. As a result, this reinforces the underlying assumptions of the researcher.

3.6 Summary

Within this chapter I have sought to summarise the rationale behind the ontological, epistemological and methodological assumptions of the study, reinforcing personal beliefs that reality is subjective and contextually constructed.

Quantitative based paradigms and methodologies were very quickly excluded as not appropriate to use in a study that was seeking an exploration of dynamic human interactions. This required a decision about the most appropriate qualitative methodology within a Constructivist paradigm to use, in order to explore the research questions.

Whilst recognising commonalities and differences between the versions of Grounded Theory, I have highlighted why Constructivist Grounded Theory became the methodology of choice. This was due to the emphasis on subjectivity and interpretation, providing flexibility, whilst maintaining the strength of the procedural framework within Grounded Theory of constant comparison and simultaneous data collection and analysis.

In addition, the appropriateness of Constructivist Grounded Theory in this study resonated due to its emphasis on the actions of participants as the focal point of the study and on the development of a relationship between the researcher and participant to mutually interpret and create co-constructions of data during the shared experience of the semi-structured interviews.

It is therefore appreciated that the outcome of this study is contextual with the very real possibility that the participants responses may have differed should the interviews have taken place at a different point in time, or with a different researcher. Indeed, there is a high possibility that my own responses to the participants' replies may also have varied in a different context.

Whilst this chapter provides an overview of the methodological approach used in this study, the following chapter consolidates the information in this one by highlighting how the study was undertaken and the processes leading to the collection of data, the subsequent analysis and generation of the findings and ultimately theory.

Chapter 4 - Research Methods

Introduction

The previous chapters explained the rationale for the study, the chosen methodology and the preliminary literature explored that was of relevance to the phenomenon of interprofessional collaboration. Within this chapter the methods employed to undertake the study, including the recruitment of participants, the data collection processes and the analysis of the data will be clarified. The findings and subsequent discussion of these will be presented in the following chapters.

The data collection and analysis processes were employed in accord with a Constructivist Grounded Theory study approach. Recognising the flexibility of these, advocated in this methodology, carrying out this research was not a linear process but cyclical and iterative (Henn, Weinsten and Foad 2009). Data collection and analysis took place simultaneously and incorporated constant comparison. However, for ease of reading, my intent is to reproduce these events in as linear way as possible within this chapter.

4.1 Ethical considerations

The aim of the study was to explore the experiences of clinical staff working within the context of intermediate care settings, to ascertain how interprofessional collaboration developed. At the outset it was important that there should be a sound ethical base for the study, ensuring that I did not contravene my own clinical "Standards of Conduct, Performance and Ethics" (HCPC 2016). This chapter therefore commences by summarising the ethical implications of operationalising the study.

Edwards and Mauthner (2002, p. 14) define ethical concerns in social research as "the moral deliberation, choice and accountability on the part of researchers throughout the research process".

As the data collection processes required the participants to share their experiences of working alongside colleagues, there was an awareness of the potential implications of obtaining this information, ensuring that processes were put in place to maintain the welfare of the participant whilst doing so.

This impacted on the choice of research design to safeguard that the processes undertaken were within the four main ethical principles of harm, informed consent, privacy and deception (Bryman 2012). These were used to reflect upon the possible impact that the study may have for all stakeholders; participants, the researcher, the university and the employing organisations.

To ensure that there was no unauthorised access to, or alteration of the data obtained from the interviews, this was secured and stored within the principles of the Data Protection Act 1998 (Denscombe 2008).

The processes undertaken to ensure the study complied with this and, that it operated within an ethical framework, are documented in the following sections.

4.1.1 Impact on the participants

Whilst investigating individual's past experiences it is not possible to predict the effect that interview questions may have on them, with the potential for it being upsetting for some. The principle of beneficence places a duty of care on the researcher not to cause harm (Polit and Beck 2010) and this was especially important as it would also contravene my professional code of conduct.

Upon completion of the interviews there were no reports of any participant who considered themselves negatively affected psychologically by their participation. Indeed, on the contrary, four participants (N2, N6, OT8 and OT9) reported to me after the completion of their interviews that

they welcomed the cathartic opportunity to discuss their current working situation.

Whilst trying to make the participant aware of what would be required of them in terms of participation it was not possible to pre-empt their responses or reaction to the questions and any potential impact that this may have on them personally. Informed consent was therefore given by them based on the information available to them at that point in time, as opposed to being fully informed consent as alluded to by Silverman (2006), which may risk contaminating the research. Significantly, the impact of this was that it required an element of trust in me by the participants for them to agree to participate.

Participants were advised that participation in the study was on a voluntary basis and that they would receive no remuneration to take part. Reinforcing the voluntary nature, they were also advised of their right to withdraw from the study at any point and that there was no obligation to take part if they did not wish to do so. No participant withdrew from the study and all participants were considered by me to have sufficient cognitive ability, at that point in time, to be able to understand the implications of the study for them, and therefore to participate in it.

As well as ethically protecting the participants from harm there is also an obligation to ensure their privacy, and the confidentiality of their contribution was maintained, with a lack of disclosure by the researcher of the participants' identities (Homan 1991). Notably this ensured the confidentiality of their individual contribution, whilst still allowing it to be included in the final analysis. To achieve this, the personal identity of all participants was anonymised at the point of transcription, offering them the assurance to be able to speak freely during the interviews.

To put it another way, Gibbs (2009) observed that participants may tell a qualitative researcher information that they would only tell good friends, reinforcing the importance of confidentiality.

In order to assure the participants that their anonymity would be maintained, they were informed that they would each be allocated a number along with the abbreviation of their profession, for example OT 1. This identifier was recorded in the header of their individual transcript and is used within this thesis in order to identify the contributions of each participant. This allowed codes to be tracked to individual's responses.

In addition, the services to which the participants belonged were also provided with a pseudonym of IC (i.e. Intermediate Care) and the numbers 1 to 5, with each service given a separate number. Any individual or organisation names to which the participants referred were also removed from the transcript in order to avoid a breach of the data.

After the interview, all the participants were thanked for their participation and provided with a copy of the transcript if they wished to have one. Upon receipt of the transcript, no participant wished to alter comments that they had made during the interview, thereby allowing the assumption to be made that the interviews provide an accurate, and continued, reflection of their personal experiences and opinions.

During the interviews participants occasionally mentioned their interactions with service users and/or their carers. At the outset of the study participants had been informed that no client related data would be included in the thesis and therefore whilst these comments were transcribed anonymously they were not coded or included as part of the analysis.

4.1.2 Impact on the study processes

As a researcher there was accountability to a number of stakeholders of the study; the university, my supervisors, but also the participants to ensure that their story was represented fairly. The transcripts were stored on a password protected computer and on two encrypted memory sticks as back up. Only I had access to these to prevent unauthorised use of the data.

To reinforce this, the Dictaphone recordings of the interviews were erased a short period of time after they had been transcribed, retained long enough to allow for them to be listened to in conjunction with the transcript. This allowed further reflection of the content. The consent forms and a paper copy of each transcript were stored in a lockable metal filing cabinet in an office to which only I had the key, again with the intent of preventing unauthorised access.

As my plans for an independent transcriber did not materialise then there was no other person involved in the data collection or the transcription of the interviews, other than myself.

4.1.3 The approval processes

Any research requiring the participation of staff, which is undertaken within the NHS, needs ethical approval (King and Horrocks 2014). As the study was part of a PhD under the remit of the University of Huddersfield then approval was required from a number of sources; the University Ethics Committee, the National Research Ethics Service Committee East of England - Norfolk and the Research and Development offices of the NHS organisations whose staff participated in the study. These all assessed the potential risks to the participants from participating in the study before allowing me to continue. A copy of the REC approval is included in appendix 1.

4.2 Sampling

4.2.1 The research settings

The emphasis of the study was on individual's experiences of working interprofessionally within intermediate care teams therefore participants were required who could provide a representative voice, were willing to participate and had the communication and cognitive skills to contribute to the study. To obtain data specific to the research aims, the data collection process targeted clinicians who were currently employed within

these services in a health care setting and who had experienced the social processes involved in interprofessional collaboration (Cutcliffe 2000).

To facilitate comparisons, approval was received to access participants working for an acute health care trust and a health organisation social enterprise both situated in the same geographical area in the North of England. The population served by these organisations also had input from three Clinical Commissioning Groups (CCGs) and two Local Authorities across two towns and a number of urban districts covering a population of around 650,000 people in total.

The diversity of data obtained by this use of multiple clinical sites, in this way, is one that is advocated by Reeves (2016), indicating that this would offer greater empirical insight into the phenomenon.

4.2.2 Access to and recruitment of the participants

The recruitment of participants for this study took place between September 2014 and September 2015.

Prior to commencing this stage of formal data collection, colleagues of the researcher participated in pilot interviews to trial the original interview guide. A summary of the outcome of this phase is provided in section 4.3.3 as this directed the approach for the formal interviews including altering the tool for how some of the data was to be visually collected, and also the construction of the interview guide.

When seeking participants for the formal stage of interviews, no requirement was placed on the length of time that staff had been employed within the intermediate care team, only that they belonged to the professions of nursing, occupational therapy or physiotherapy and that they were currently working clinically.

The rationale for concentrating on these three professions was that I was aware, from my personal experience that these comprised the core professions of the majority of intermediate care teams.

Initially, purposive sampling was utilised to identify the first team to be interviewed. This was justified as a means of obtaining relevant data from which a direction for theoretical sampling, in accordance with Constructivist Grounded Theory studies, was later taken (Cutcliffe 2000, Horsburgh 2003). To gain access to further participants, contact was made with the team leaders of services who were identified, following theoretical sampling, to seek volunteers.

King and Horrocks (2014) suggested that a researcher was more likely to be successful with the recruitment of participants if assistance was received from an insider. This approach was confirmed within this study as a useful one as, within the services participating, the team leaders all liaised with their staff on my behalf about the study, thereby providing an alternative route to communicating with them and obtaining their participation.

Upon receipt of the potential participants' names and contact email addresses, they were forwarded the research information sheet (see appendix 2); with some dates for interviews to take place. At the same time staff were offered the opportunity to seek additional information from me about the study prior to proceeding, however none of them felt they required this.

None of the staff who had volunteered to participate wished to withdraw from doing so and to maintain this commitment it was necessary to work flexibly, arranging mutually convenient interview times and communicating with them either by email or mobile phone depending on their preference. Due to the need to accommodate the participants' different shift patterns and to arrange a suitable venue to hold the interview in, the interviews were arranged between 14 and 28 days from this initial contact.

4.2.3 Theoretical sampling

Theoretical sampling, a form of sampling that is responsive to the data (Corbin and Strauss 2015), is a feature of Grounded Theory whereby relevant participants are specifically identified who can help to develop the emerging concepts and who are able to offer “meaningful insights into the phenomenon” Nicholls (2009b, p. 640) with the aim of constructing theory (Coyne 1997, Boychuk Duchscher and Morgan 2004, Corbin and Strauss 2015). It takes place after the initial sampling and initial data collection and analysis has been undertaken and when there are “some preliminary categories to develop” Charmaz (2014, p. 205).

Theoretical sampling assists in the emergence of data as it involves making decisions about “what data to collect next and where to find them” (Glaser and Strauss 1967, p. 45, Holton 2008, p. 9). This is determined by the simultaneous collecting, coding and analysis of data characteristic of a Grounded Theory study. It is an appropriate fit for this exploratory study as it provides the flexibility to seek out data and participants based on existing concepts, identifying patterns so that new insights into the phenomena are obtained (Corbin and Strauss 2015, Polit and Beck 2010, Birks and Mills 2011). This is in contrast to the study progressing along a route pre-ordained by the researcher.

Dey (2007, p. 186) notes theoretical sampling is an “instrument for generating theory, not investigating cases”, used not to verify hypotheses but rather to discover concepts. It is used to flesh out the properties of categories and to develop links between them (Charmaz 2014) in a way that fits the needs of the study. Due to this it is not possible to pre-empt at the outset of the study the number of participants or type of data required (Birks and Mills 2011), as the direction for data collection is led by the emerging concepts, ceasing once theoretical saturation is achieved (Boychuk Duchscher and Morgan 2004). This is a particularly relevant statement for the study within the thesis as the proposed sample size was

subsequently doubled to respond to theoretical requirements, once the concepts started to develop, in order that theoretical sufficiency was eventually achieved. In addition, at the outset of the study it was also unclear where, and how to access participants to take part in it.

Taking this, and the above into consideration, when determining which new services to approach for interviews to elaborate the information already obtained, the interview participants (including those in the pilot phase) were asked to suggest other services who also worked across traditional professional boundaries in intermediate care whose experiences may be pertinent to the aims of the study.

The inclusion criteria for the study was that participants would be clinically active and belong to the professions of nursing, occupational therapy and physiotherapy, as these were the core professions identified within the NSF for Older People within intermediate care settings. Whilst it is recognised that other professions and disciplines are involved in this type of service, the Team Circles exercise reinforced that these were part of an extended network of colleagues, as opposed to part of the core service. As a result, a decision was undertaken, due to the practicalities of access to these staff, to restrict interviews to practitioners from the three core professions.

With hindsight it may also have been useful to include the rehabilitation assistants from each service in the interviews as these members of staff, are a key part of the services but have work delegated to them by the clinicians and therefore may have offered a different perspective in terms of interprofessional interactions. Their lack of participation in this study, instead offers scope for further exploration of these relationships.

Morse (2011, p. 231) reinforces that "An excellent participant of Grounded Theory is one who has been through, or observed, the experience under investigation." It was considered that by seeking potential new avenues for exploration from the participants themselves,

this would increase the relevancy of the services sampled and assist in the continued emergence of the concepts already identified from previous interviews. Through the constant comparison of data from the different sites accessed within this study, the intent was that this would also add to the existing categories and advance the conceptual framework of the study to refine the theory.

Rather than returning to the existing participants to seek out additional information, alternative sources of data were sought from different services in order to compare and contrast with the existing findings and allow for theoretical development by offering a wider range of viewpoints and description of experiences. However, in doing so this created a slight delay in the timeline of the study, due to the practical requirement to seek ethical approval from the employing health organisations prior to making contact with participants.

Figure 3 offers a brief overview of each service participating in the study, putting into context their current working situation. The arrows in this diagram indicate how further services were identified, by those already participating in the study, to contribute to developing the emerging concepts and to offer fresh insights into the phenomenon. The brief overview highlighted in figure 3 is followed by further information about the contextual settings for each service. A more detailed description of the impact of these contexts on the participants is provided in the following section.

It transpired that each service was operating at different stages of development, either having experienced a service re-design, were in the process of re-design, or were aware that changes to their service were planned. This provided valuable insight into a variety of contextual settings and the processes that the participants were undertaking, within these, to establish interprofessional collaboration.

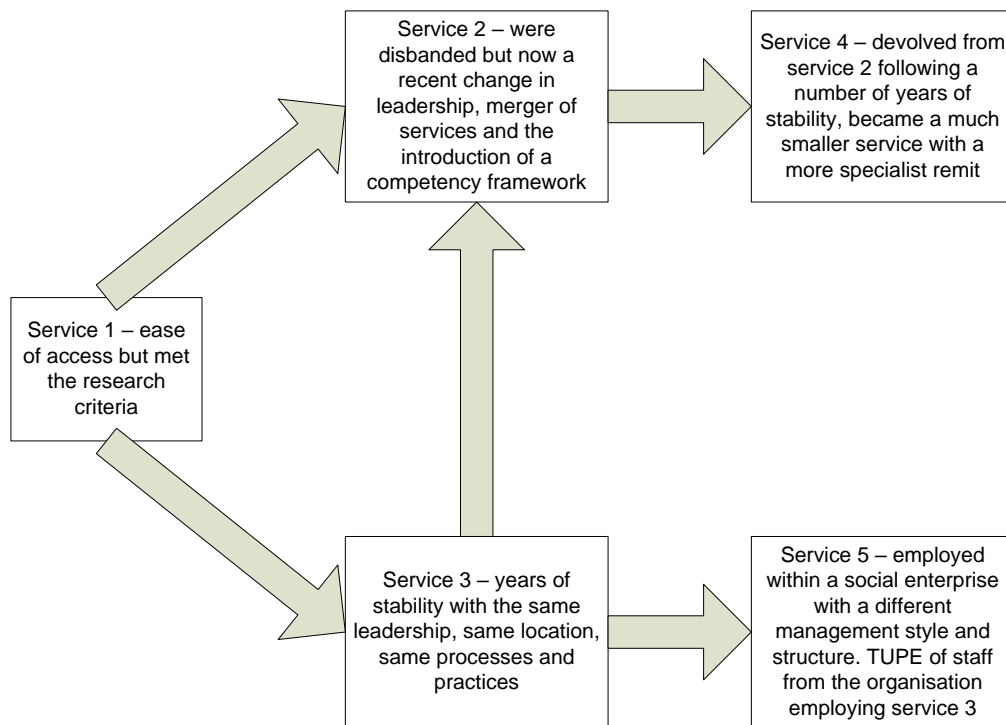


Figure 3 Comparison of the services participating

From an organisational perspective IC services one to four were all employed by the same organisation but with different strategic managers and were sited across two towns and two local authorities.

IC service five was employed in a social enterprise covering the population of a metropolitan council.

IC services one, three and five were commissioned by the same CCGs and teams two and four by different CCGs.

The participants within all of the services used a shared IT system and also shared clinical recording documentation that was specific to their services. A key concern for each of the services was of their ability to be able to safely meet the needs of their patients due to the volume of work they received.

4.2.3.1 Contextual settings

IC 1 was a service provided by an acute hospital trust, where patients admitted to it received intervention in their own home for a short period of time. Participants reported that IC 1 had been operational for approximately twelve years and that they had experienced a period of stability for some time as the last major change, significantly impacting on them, had taken place approximately five years previously. During this change it had moved from a purpose-built rehabilitation unit, housing a number of rehabilitation services, to, what the participants described, as a cramped office situated within an acute hospital.

This had resulted in a lack of available working space for all the staff to be in the office at the same time, plus a lack of parking facilities. In addition, participants had recently been provided with lap tops and the facility to work from home, thereby negating the need to attend the office as often.

Participants expressed concern that the existing period of stability was likely to end shortly as the commissioners had made the decision to put the service out to tender to any qualified provider. They were aware that potentially this may mean that they could possibly be transferred to a private provider. The outcome of this tender process was not known at the time that the interviews took place, and there was also uncertainty as to the impact on the participants' roles due to a lack of information available about how the service would operate in future.

The current situation within this service was that referrals were received from other professionals only, predominantly hospital based staff, GPs or community based nurses or therapists. Participants reported that they were not able to use their discretion to decline referrals but were expected to manage the patient's needs once they were on the service.

IC 2 was also employed by the same acute trust as IC 1, it had undergone a period of transition two years previously when the service

was initially disbanded and then redesigned to provide interventions to people in their own homes.

Whilst previously health and social care staff, working within this service, were housed in different offices these two groups of staff were merged together, as part of the redesign, to be co-located in the original base of the health employed staff. This had taken place at short notice and required a review of the available office space to accommodate the new staff members. The office now housed twice the number of staff to what it had done previously as a result of which filing cabinets and other resources used by those originally based in the office had to be re-sited or removed completely. Due to the restricted space available, and insufficient desks for all staff, participants were expected to “hot desk”, using any vacant desk, rather than having dedicated desks, as previously, that they were able to keep personal items in.

As part of the redesign process it was agreed that all the staff in the service would wear the same generic uniform. This predominantly affected the nursing and therapy staff who had previously been identifiable through their respective professional uniforms and who were now indistinguishable from assistant grade staff. This was a situation that two of the participants affected were particularly unhappy about.

When the team was redesigned it was commissioned as a pilot for a year. No decision had since been made as to whether it would become a permanent service with it recently extended for a further year. Uncertainty therefore remained as to the future of the service and the roles required within it.

Within this service referrals were received from other professionals only, predominantly hospital based staff, GPs or community based nurses or therapists. Similar to IC 1, staff were not able to use their discretion to decline referrals but were expected to manage the patient’s needs once they were on the service.

Unlike the previous two services, who provided intervention in patient's homes, IC 3 is a bed based intermediate care service receiving referrals from the acute hospital to facilitate discharge and from GPs to prevent admission to hospital. It is situated within a Local Authority care home with staff having a permanent office base within the home which adequately housed all staff members and operated as a dedicated rehabilitation unit.

Staff within the unit were not able to use their discretion to decline referrals but, as in the previous two services, were expected to accept the patient and then manage their needs once in the unit. If they did try to decline a referral from the hospital wards they reported that they were over-ruled by strategic managers who would ring the unit and insist that the patient was admitted in order to free up a hospital bed. Participants expressed concern that on occasions patients were admitted to their unit, from a hospital bed, who were not medically stable. They therefore felt that this placed the patient, as well as the staff at risk.

At the time of the interviews the nursing staff, within this unit, worked a shift pattern covering the service seven days a week. The therapy staff worked a five-day shift pattern. There was therefore no therapy provision on a weekend. However, in order to equalise this, there were plans for the therapists to introduce a seven-day shift system. They were advised that this would be introduced without the provision of any additional staff therefore this would require a reduction in the number of therapists working each day to accommodate the increased number of shifts.

The service had not undergone any significant change for approximately fifteen years therefore had experienced an extended period of stability in terms of how it operated. There was an increased awareness that this stability was going to be eroded as this service was also included in the community tendering process with IC 1 thereby resulting in uncertainty as to who would employ staff in future, or how the service would operate.

IC 4 provided intervention for patients in their own homes but also admitted them to intermediate care beds too when required. Unlike IC 3, this service used beds commissioned within private nursing homes. Due to the lack of jurisdiction over the care staff employed directly by these homes there was concern about the quality of care that they provided and the potential for safeguarding concerns. In spite of these concerns the participants reported that the commissioners of the service still insisted on purchasing beds from these private providers for use within this service.

In addition, staff had no dedicated office in these homes and were required to travel between these units and their main office base within a health centre, therefore they were limited in the amount of time that they could spend in the units to oversee the interventions provided by the privately employed staff.

IC 4 had been operational for approximately seven years but had been re-designed on numerous occasions therefore had had different guises for how it operated. Staff within the service were previously employed by a Primary Care Trust but, as part of a more recent re-design, had transferred into an acute trust along with other community based therapy and nursing staff within this geographical area. A positive impact of this transfer had been the provision of additional funding to employ an increased number of therapy and nursing staff within the service. This had encouraged a period of stability within it, although due to previous experience of frequent changes, participants were unclear about how long this stability would last.

Unlike the previous three services, IC 4 had a proactive admissions process and would triage referrals received from community based staff, carers, GPs or hospital wards in order to ensure their suitability for acceptance onto the service. Whilst still occasionally facing challenges from referring sources, they therefore had more control, than IC 1, 2, 3

and 5, over who they could admit onto the service. This provided them with a greater confidence of the patient's medical stability.

IC 5 had been operational for approximately four years and provided intervention for patients in their own home. Whilst this service was hosted by the Local Authority, the clinicians working within it were employed by a health based social enterprise. Other staff within the service were under the direct employment of the Local Authority. The impact of staff from different organisations working within the same service was that there were differences in management structure, processes and terms and conditions. This was reported by the participants as creating confusion at times between them due to uncertainty about processes.

The service was housed in a Local Authority building and received referrals from hospital or community based staff, or self-referrals from the client or carer. There was a small amount of triaging of new referrals undertaken to ascertain their suitability for acceptance, however this was not to the same standard as that within service IC 4.

As part of a wider scheme of redesigning other community based nursing and therapy services, there were changes planned to IC 5 to incorporate it into a locality hub. Whilst staff were aware that this would be happening shortly, it was unclear how this would affect them or what the final specification of the service would comprise. Due to this uncertainty a number of staff had left the service and their jobs remained vacant. This therefore impacted on the existing staff to cover their own, as well as the vacant roles. Participants reported that there was still the expectation placed on them to provide interventions for the same numbers of patients even with staff vacancies.

Whilst working within the mainstream intermediate tier of services, all five services within this study therefore had their own unique contextual settings. In spite of this, there were similarities in stressors and demands affecting each of these and these will be described further in chapter five

which discusses the findings of the study. The following section will provide a summary of the demographics of the participants, working within these settings, who contributed to this study.

4.2.4 Demography of the participants interviewed

All of the participants were women with post qualification periods varying from just three months to thirty-eight years and working in Agenda for Change grades 5, 6 and 7. This therefore offered diversity of professional experience.

Nursing staff were the smallest profession represented, comprising just six nurses compared to nine each of occupational therapists and physiotherapists. This was not unduly concerning, however, as this is indicative of the ratio of nurses to occupational therapists and physiotherapists working within the intermediate care services participating in the study.

Participants had been employed in their current role from between three months to fifteen years with eight of them joining their teams at the outset of its development. All participants were working in an operational role which involved providing clinical interventions to clients on a daily basis. This was particularly valuable as the roles involved working closely with colleagues from different professions and organisations and it was these interpersonal relationships that participants were required to converse about during the interviews.

All of the participants were therefore triaged as a suitable fit to participate in the study based on this information.

4.3 Data collection processes

Whilst Charmaz (2014, p. 23) suggests that rich data provides a solid basis for "building a significant analysis", Polit and Beck (2010, p. 370) highlight that there are few data collection procedures that will capture data "in a way that is accurate, truthful and sensitive." This is of

particular relevance within a qualitative study where there is the appreciation of multiple, subjective realities.

The rationale for using Constructivist Grounded Theory is that it has the advantage, as do previous versions of Grounded Theory, of enabling data to be gathered in a diverse number of ways, with the researcher identifying the one(s) that would answer research questions in as close as possible a way to Polit and Beck's ideal. Whilst appreciating this flexibility it is recognised that the appropriateness of methods to answer the research questions posted needs to be evaluated before making a final decision about which methods to use.

Whilst considering the possible use of participant observation, focus groups and questionnaires, these were all disregarded as not suitable to provide the quality of data required for this study. It was concluded that semi-structured interviews, on an individual basis, were instead more pertinent as the method of choice. The rationale for making this decision will now be examined as to why these would obtain richer data relating to the interpretation by the participant of their experiences.

4.3.1 Interviewing

King and Horrocks (2014, p. 1) suggest that "interviewing is the most commonly used method of data collection in qualitative research."

Through interacting with the participants during the interviews they provide a window of their world through their eyes (Miliken and Schreiber 2012), to enable us to seek understanding and compare it with other participants' perspectives and that of the interviewer to abstract further understanding.

Interviews are a flexible approach to data collection as they allow the researcher to ask questions to seek out and gain knowledge and understanding of the phenomena, based on the responses to these by the participants (Fitzpatrick and Boulton 1994). Interviews vary in content in that they may be unstructured, structured or semi-structured, undertaken

on an individual basis or part of a focus group, thereby providing a flexibility of approach based on the needs of the study.

Whilst focus groups can offer a wealth of information due to the potential synergy created through interactions between participants, my intent was to obtain individual, as opposed to collective, interpretations of the participants' experiences, hence the decision to interview the participants on a one to one basis.

Limb (2002) suggests that unstructured interviews offer a wider response but can be difficult for the participant to focus on the phenomenon, as they have a brief number of prompts, whereas structured interviews are more rigid, with a fixed script so that the participants are asked the same questions in the same order (Polgar and Thomas 2008, Fontana and Frey 2005).

The latter approach does not allow for the same flexibility for the participants as unstructured or semi-structured interviews and also places control in the hands of the researcher (Smith 2008). Taking this into consideration, a structured approach does also allow for standardization of the interview process and therefore reduces the risk of errors (Bryman 2012).

As the emphasis in Constructivist Grounded Theory is on the interaction between participant and researcher and the co-construction of reality (Charmaz 2011), semi-structured interviews, with identified topics to use as prompts, were determined as most relevant to obtain the majority of data collected in this study. In addition, face to face questioning, with one person acting as interviewer for all the participants in this study, ensured a consistency in approach, with the product of the interaction between the participant and researcher being the co-construction of information.

As previous research studies had already used interviews effectively to investigate interprofessional collaboration, this approach therefore fitted comfortably with the intent to explore the thoughts, experiences, ideas

and activities of the participants. This also encouraged them to talk openly about these, whilst allowing for further questioning, in order to seek greater understanding of these and the emergent concepts.

As expected with a semi-structured interview approach the interviews started with an underlying topic and then were led in the direction taken by the participant. Whilst the participants were asked questions that were similarly worded, the transcripts clearly demonstrate that no two interviews were constructed identically therefore reinforcing the diversity of the participant's experiences and responses.

4.3.2 Devising the interview guide

When undertaking interviews Charmaz (2014, p. 62) advocates the use of an interview guide and suggests it be used as a "flexible tool to revise." The original intent of the interview guide was to act as an 'aide memoire' rather than a structured tool for use identically with each participant. It was used flexibly and adapted depending upon the construction of the responses of each of the participants. It was later used in a more focused way, following data analysis and comparison.

Due to exploring the phenomenon of interprofessional collaboration using an approach where the participants would direct the study, the interview guide formed a baseline for the interviews in the form of a framework of suggested topics for discussion (Carey 2010).

From the preliminary literature review undertaken at the start of the study a small number of sensitizing concepts were identified to use as guidance for "points of departure" (Charmaz 2014, p. 31) of the data collection. These concepts were used to generate the first incarnation of the interview guide and were subsequently revised, along with the guide, following the pilot interviews to comprise team construction, development of the team, team member interaction and decision-making processes.

These concepts were identified as of importance to the pilot study participants at that point in time and therefore it was perceived that they would be of relevance to shape the interview guide for future interviews, to seek out additional information to explore and refine them further. A copy of the sensitizing concept diagram is available in appendix 3 and the interview guide in appendix 4.

4.3.3 Pilot study experiences

The pilot interviews were undertaken with colleagues from my own organisation. Four members of staff were interviewed who all worked in the community in close contact with intermediate care services and also comprised the professional groups of occupational therapy and physiotherapy. In effect these staff met all of the study criteria apart from actually working in an intermediate care setting. A nurse in the team was approached to participate but did not opt in.

The purpose of the pilot study was two-fold; to practice undertaking an interview in a research context, but also to evaluate the processes of the interview and identify whether any improvements were required to these. Whilst the data obtained from these interviews was excluded from the final findings, concepts began to emerge from them that helped to shape the interview guide by altering the juxta positioning of the interview topics to allow for a more improved flow of questioning.

As well as reviewing the interview guide the pilot interviews were an opportunity to review the proposed visual imagery tool intended to assist in data collection and analysis. The following two sections will highlight how the original intent to use Pictor was subsequently replaced by a documentation tool devised specifically for this study; Team Circles.

4.3.4 Pictor

Pictor is a research tool used to “explore experiences and understandings of inter-professional working in a community healthcare setting” (King and Horrocks 2014, p. 191).

It produces a visual representation of networks of interaction between those involved with a particular patient. The intent was to provide clarification of the individual’s perception of their relationship with others and how participants are positioned in relation to each other during their interventions.

The rationale behind using this was that it would encourage participants to reflect on how individuals interact, producing a visual image of the working relationships between the patient and the different professionals.

However, following a review of the transcribed pilot interviews and after one formal interview, it was identified that where relationships between staff and patients were discussed, the staff members would concentrate on the relationships between themselves and the patient, to the detriment of discussing the interpersonal dynamics between staff members providing clinical interventions for that individual. Whilst this reinforced the extent of patient-centred practice, the interviews presented as fragmented, as participants required frequent prompts to return to reflecting on their interpersonal interactions with their colleagues.

An online search to locate a visual imagery tool to obtain more pertinent information relating to how colleagues were actively positioned in relation to each other, both within teams and within the wider networks that the participants operated within, proved unsuccessful. The Team Circle diagram was therefore devised for the purposes of this study as an alternative means of generating and visually representing data to be utilised instead of Pictor. The role that this played in the interviews is discussed below.

4.3.5 Team Circles – a comparison of team construction

The concept of the development of the Team Circles tool was instigated from the comments of OT 1 who suggested that HER core team of colleagues altered depending upon the patient's need. This therefore varied for each individual even though, as a clinician she was part of an identified and structured service. This reinforced Allport's (1954, p. 36) historical view that members of the "same actual in-group may view its composition in widely divergent ways".

During the course of everyday conversation the term "inner circle" is often used to describe a close knit group of people. The Collins dictionary suggests that it may be attributed to "a clique or a group of people, or who share a common interest, aim or purpose,"

(<http://www.collinsdictionary.com/dictionary/english/inner-circle> - Accessed 3rd November 2015).

OT 1's comments therefore directed me to reflect on who the participants would consider to be part of their professional "inner circle" and whether, by providing those employed within the same service with a visual tool to represent this, there would be consistency in their responses.

The participants were provided with a blank copy of the Team Circle diagram (see appendix 5) following the introductory part of the interview. They were asked to consider the colleagues they interacted with within their immediate and wider network, and to visually represent this on the diagram. The advantage of this approach was that there was no reference to patients specifically in the instructions. It was therefore the prerogative of the participant as to whether they wished to include them within their visual representation.

All the participants were provided with the same written instructions and the opportunity, within the interview, to complete the Team Circle diagram without any time limit allocated to this.

They were also all provided with a standardised verbal instruction; “Include on the inside of the circle those professions you consider to be part of your core team.”

Participants were advised that if they felt confident that they had included on the inner part of the circle all the professions and teams that they wished to, then they could stop listing those on the outside of the circle, however they were encouraged to be as inclusive as they deemed necessary.

Following completion of this, the participants were asked to articulate why they had positioned their colleagues either inside or outside of the circle. Due to the simplicity of this request, this exercise was also perceived as an ice-breaker, encouraging the participants to offer their responses in a way that was led by them.

4.3.6 Undertaking the interviews

Based on the experiences of the pilot interviews it was anticipated that the formal interviews would last around forty-five minutes each, after the housekeeping of the interview (i.e. explanation of the remit and confirmation that all responses would be kept confidential, and any person or organisational identifiable data would be anonymised) had taken place. Upon completion of the study, the average time per interview was forty-three minutes, with a range from twenty-nine minutes, to one hour seven minutes.

Prior to commencing the interview each participant was asked to complete the consent form so that there was a written record of their agreement to participate. A blank copy of this form is available in Appendix 6.

As part of the introductory component of the interview, the role of the researcher, for the purposes of this study, was explained and that it was being undertaken as part of a PhD affiliated to the University of Huddersfield. Participants were therefore aware that the study was

independent of their employing organisation and that this would not have access to any of their responses. The intent of informing them of this was that it would offer them further reassurance of confidentiality of their responses.

My intent at the start of the interviews was that I did not wish to pre-empt or guide the participants' responses, therefore I deliberately did not declare my previous knowledge and experience of working in intermediate care services at the outset of the interviews. I considered that by sharing this personal information about myself the participants may anticipate that I would expect certain responses, whereas I needed them to share with me a description of their own personal opinions and experiences. However, in withholding this information there was also a potential risk that this would impact on the interaction, the development of mutual trust and the building of rapport with the participant due to, what they may perceive, was a lack of common ground between us.

In accordance with a Constructivist Ground Theory approach it is not suggested that interviewers should be passive, but instead, by developing a rapport and a state of equity between the researcher and participant, this assists the interview to be "an open-ended, in-depth exploration of an area in which the interviewee has substantial experience" (Charmaz, p. 2014, p. 85). This is described by Birks and Mills (2011, p. 56) as a process of "narrative interaction" during which both the "participant and researcher give and take from each other" to construct knowledge. This minimises the distance between the researcher and the phenomenon through the mutual interpretation of actions and meanings. Where I was uncertain of the meaning of the participant's responses then I sought to clarify these through further questioning, but also where participants actively questioned my clinical background in relation to intermediate care then I responded honestly, summarising this for them.

Participants were offered the option of having interviews undertaken in their own department or workplace, should this make them feel more

comfortable and decrease travelling time for staff. However, they were also provided with the option of attending the interview in an independent setting if they wished. All indicated they were happy to meet in their existing workplace and either the team leader of the service or the interview participant identified and booked an appropriate room for the interview and informed me of the location of the room. This assisted with the organisation of the interviews.

The process that each interview took varied depending on the response from the participant. This was an advantage of semi-structured interviews in that questions or topics could be discussed in a flexible format, or follow up questions could be asked in order to accommodate or clarify the participant's responses (Bryman 2012).

This approach could be described as requiring effective listening skills and offered greater flexibility during the interviews, allowing the interviewer to respond to emerging issues (King and Horrocks 2014) as they arose. An outcome of this was that it provided the opportunity for the conversation to take alternative and sometimes unexpected directions.

Henn, Weinstein and Foad (2009) suggest the collection of data can be chaotic with the revision of questioning taking place following the analysis of early data. The revision that took place, within this study, following this, led to a greater emphasis on the relationship dynamics within the teams and the impact that internal and external stressors had on these.

During the interview the aim was to create an environment where the participants perceived that they were able to respond freely, hence by asking them to talk about themselves in the initial stages, the intent was that this would relax them and encourage them to consider their role within the wider team and their relationships with others. From this point there was an opportunity to expand on this information further. By assuring them of the confidentiality of their responses there was also an

intention that this would encourage them to be able to speak openly and honestly without fear of reprisal.

In accordance with semi-structured interviewing, introducing questions sought out initial information about the topic, for example "please tell me about your experiences of working with your colleagues in this service" and these were then followed up with additional questions based on the participants' responses to clarify the points that they raised.

This was also an opportunity to seek clarification of the participant's responses by asking them to expand on their original answer to elaborate it further and also for me to give my perception of their answer and check whether this perception of their response tallied with their own.

On some occasions the participants found it difficult to answer the question, for example when asked for a definition of collaboration. They had habitualised this way of working to the extent that they stated that it was something that they did subconsciously therefore were unclear how to explain their actions. Some asked for a period of reflective time in order to consider how to articulate their answer and they were allowed as much time as they required to do so.

The participants were allowed to direct their responses which, upon reflecting upon the transcripts, may appear as though some participants diversified significantly. However, the rationale was that, as an interviewer, I did not want to miss out on any information that the participants considered was relevant which may send the study into different directions, including ones that would not otherwise have been considered. An example of this may be seen in a response from OT 1 who when asked which professions she considered to make up her team responded by saying that she considered that each patient had a unique group of people working with them depending on their needs. This contrasts with the more restricted thinking of a team being stable in

terms of its make-up and led to further consideration of how stability of inter-relationships can ensue in such interchangeable groups.

The following section will summarise the processes undertaken to record the findings from the interviews.

4.4 Recording the participation

To assist with the analysis of the data, it was essential that the interviews were recorded correctly using a method that would collect as much information as possible, but also would not be intrusive so as to prevent the participant from being able to talk openly. A combination of audio recording and field notes was used to do so.

4.4.1 Use of audio recording.

Audio recording of the interviews allowed for them to be transcribed and for the recording to be referred to on more than one occasion during the analysis stage. The consent of each participant was sought prior to commencing recording.

Recording the interviews enabled the participants to be offered my full attention and to concentrate on their responses (Charmaz 2014) as opposed to trying to quickly make notes as they talked. This allowed the conversation to flow, rather than risking it being disjointed by halting the discussion to document pertinent points (Charmaz 2014).

It also provided the confidence that any relevant points, which were being made by the participants, would not be missed during the analysis stage. An additional advantage of this is that as recordings could be listened to more than once it was possible to pick up the nuances of the participants' responses and reflect on the content, in order to review the interpretation of them over a period of time. This provided further insight into the phenomenon, as new concepts emerged, that were not immediately obvious whilst the interview was taking place. Upon reflection, this was a

more considered approach than having to make a judgement at the point in time of the interview or rely on memory.

An example of this was the emphasis placed by the participants on the lack of support offered to them by those working at a strategic level in their organisations. Initially, when analysing the data, this was perceived as a negative situation, however as more interviews took place, it was possible to extract from them that it actively encouraged operational staff to work together more cohesively, as they were developing coping strategies to support their colleagues, but also to unite against the stressors affecting them.

The audio recordings were complemented by field notes produced upon completion of each interview which were also used as a reflection of how the interview had progressed and to record further changes to the process, should they be required.

4.4.2 Producing field notes

Hand written notes were produced about the interview once the participant had departed the room and the interview could be reflected on in private. These were used as an opportunity to highlight the key points from the interview and whether there were any new concepts which had emerged that were immediately identifiable.

Once the interviews were transcribed a summary of these field notes were attached to the transcription as supplementary information, for comparison with other data.

4.4.3 Transcribing the interviews

Interviews were transcribed verbatim and coded. To ensure consistency of transcription, guidance was produced to be followed by a transcriber so that the layout of each interview transcript was identical. A copy of this guidance is available in appendix 7. Whilst the original plan was for an

independent transcriber to transcribe all the interviews, this did not materialise and I transcribed them all myself.

Following the guidance, all of the transcripts were treated in the same way with the lines of the transcripts all given a number so that any data could be easily cross referenced. All references to any individual, service or organisation were also removed and replaced by a pseudonym.

The participants were advised that a copy of the transcript could be sent to them to verify post interview. This was in order to ensure that it was a true representation of their responses (Letts et al 2007), but also as a failsafe for them, just in case there were any responses that they felt they no longer wished to share and to withdraw data prior to it being potentially included in the findings.

All but two participants agreed to receive a copy of the transcript, one of these saying that she would not have time to read it and the other stating that she trusted the content would be accurate and did not need to see it.

Upon receipt of the transcripts no participant suggested that there had been a misrepresentation of their comments or that they wished to withdraw anything that they had said during the course of the interview. This offered an indication of stability in the views offered at that time.

4.5 Analysing the data

The data obtained from the interviews contained very personal perceptions, values, beliefs and emotions from the participants. A data analysis tool was therefore required that allowed the comparison and contrasting of the data simultaneously to direct the collection of additional data further, (Charmaz 2014) in accordance with the flexibility of processes advocated within Constructivist Grounded Theory methodology.

As mentioned previously this was not a linear process but one where the data was frequently revisited, reinterpreted and relabelled. The following section will explore this in more detail.

4.5.1 Initial coding of the data

Coding of the data commenced following completion of the first two interviews rather than waiting for all data to be collected. It was an iterative, comparative process that involved frequent reviews and interactions with the data.

Recognising the positioning of the researcher in the coding process in Constructivist Grounded Theory, analytical questions are asked of the data (Charmaz 2011). To commence initial coding, incidents were used within transcripts as the point of reference to fragment the data (Kelle 2007). The term incident may be considered to be; "an umbrella term for recurring actions, characteristics, experiences, phrases, explanations, images and/or sounds" (Birks and Mills 2011, p. 93) to explore the meanings of the data further and to develop concepts.

The use of incidents was considered to be a more meaningful and manageable approach than using words or lines as the fragments due to the volume of data collected from 24 semi-structured interviews.

A code was applied to each incident which Robson (2002, p. 477) describes as "a symbol applied to a section of text in order to classify or categorise it." Through the identification of patterns and the construction of relationships between them, these were integrated into concepts and categories. Corbin and Strauss (2015) comment that grouping the data based on common characteristics reduces the amount that the researcher has to work with and this was certainly an advantage based on the number of codes obtained from each interview.

To apply the coding process to the transcripts they were read and re-read to start to interpret the content and consider the potential multiple meanings of the participant's words. In line with Constructivist Grounded Theory, the incidents were labelled using gerunds, emphasizing the actions and processes, which summarised the content of the fragmented

piece of data. Examples of the use of gerunds as codes are provided in Appendix 11.

When reading the transcript to code the data, the context that the participant was describing was considered. However, trying to make sense of how the participants make sense of their world became a very slow and laborious process which became quicker as greater familiarity with the data was achieved.

Codes started to emerge from the data (Charmaz 2011) following the interpretation of the participants' responses, recognising (Charmaz 2011) the impact of the researcher's previous experiences at this point in informing the analysis and noting the need to be aware of this and to keep an open mind when coding. This lack of neutrality by the researcher was integral to enabling connections to be made within the data based on the interpretation of the participant's experiences.

This approach allowed for fragments of text to be compared with those that had been previously coded and note similarities and differences, in content and context (Boychuk Duchscher and Morgan 2004). As a result, the generation of patterns and themes of codes and, subsequently categories, raised questions of the data (Gibbs 2009); both in terms of needing to seek additional information about the findings but also to question gaps in it that were evident, that later interviews could be used to explore further.

This early stage of coding comprises an interpretation of the data (Robson 2002). Whilst Glaser (1978, p. 57) asked the questions "What is this data a study of?", "What category does this incident indicate?", and "What is actually happening in the data", I followed a lead set by Charmaz (2014, p. 116) who asked the same questions as Glaser but also asked "What do the data suggest?" in order to apply meaning to the incident recorded.

By coding the actions noted by the participants sometimes more than one code appeared on each line of the transcripts. Codes were written in the left-hand column of the transcripts and were then recorded manually on an ever expanding spread sheet which documented the code, the identification number of the participant, the line number and verbatim text to which it related. It was possible therefore to track the code back to the transcript and the participant it came from. In order not to direct the findings no a priori codes were included on the spreadsheet, the only codes documented on it were those that emerged from the data obtained.

By working in this way, it was also possible to compare data from more than one transcript, interpret the context and identify whether there was the potential for the same code to be attached to each piece of data or whether I would perceive a different meaning and therefore a different label to ensure the best fit for each (Charmaz 2011). The emergent codes were therefore grounded in the data.

As a result of the process above, the initial codes did not always remain static. An example of this is where I reviewed ***Having discussions between group members*** and ***Talking to others*** and considered that the meanings were similar in that both were describing how colleagues congregated to talk through events or issues, they welcomed the support of others with. These were subsequently merged together under the code of ***Talking to others***.

Where the same code was used more than once, a definition was attributed to that code to ensure that it was attached to similar statements consistently. However, each piece of data was only allocated one code. The intent of this was to reduce the risk of creating confusion and a large amount of codes that required data management.

On the spreadsheet each service was colour coded. This allowed for ease of comparison between the different members in what became an increasingly large document. By collating all participants' codes on one

spreadsheet this enabled comparison of data on a service by service basis but also to cross reference them by profession too to identify the emergence of concepts.

4.5.2 Focussed coding

Charmaz (2011, p. 57) describes focussed coding “as the second major phase in coding.” In this phase data is reformed through the grouping of codes to create concepts and listed under a subcategory heading.

Concepts comprise the classification of items within the data that were interpreted as sharing “some common properties”, (Allan 2003, p. 3, Corbin and Strauss 2015, p. 76). Comparing each of the concepts with others and, linking together those that were perceived to have similarities, led to the identification of a number of higher order themes or sub-categories, from the transcripts. An example of this is where the concepts of ***Interacting with others, Showing an affinity for colleagues*** and ***Being aware of other’s abilities*** were grouped together to form the sub-category of ***“Awareness Of Others”***. This process of discovering interconnections between concepts provided the basis for building the theory (Allan 2003, Bryman, 2012) and an explanation of how this abstraction was undertaken for all the data will be provided in the following chapter.

In order to undertake this, a structural framework, was not followed in order to ensure that the exploratory nature of coding was maintained and not restricted, as has sometimes been suggested in relation to Strauss and Corbin’s axial coding (Bryman 2012).

Instead Charmaz’s lead was once again followed through using initial and then focused coding. This led to the construction of sub-categories and categories that reflected “how I made sense of the data” (Charmaz 2014, p. 148), with the resultant theory generated grounded in the data as it was interpreted from it and no other preconceived hypothesis. A visual

imagery tool was devised, for the purposes of this study, to record the categories that developed from the data analysis.

This tool was entitled "Locating the categories" and a copy of this is included in Appendix 8. This provided a tiered approach to recording the themes based on their presence in the data. The themes that were constructed as core to the data were documented in the centre box. These were a combination of interpersonal issues and process driven ones. The interpersonal themed issues were also in the middle box and process driven ones on the periphery. These were positioned in this way due to the interpretation of the meanings applied by participants to them during the interviews.

Tentative connections between the concepts were constructed and were modified as new information and fresh insight became available through the process of constant comparison. As discussed previously, the codes and concepts that emerged from the data were also recorded on a spreadsheet. Due to the vast amount of data that this comprised I was concerned that the emergent sub-categories could potentially be lost within this recording and, as a result, devised a means of separating them out from the rest of the data for ease of continued comparison and contrasting of the findings.

The "Locating the categories" tool was therefore completed for each service, offering assurance of a visual tool to refer to in order to quickly note the development of the sub-categories and identify areas where additional information to populate them could be sought from the participants. This allowed the data to be considered in a more flexible way through visualising the connections between them.

In particular, the strength of the systemic functions; strategically, organisationally and environmentally, on the development of interprofessional collaboration emerged at this point, recognising how the stressors attributed to these functions actually, when explored further,

had a positive effect on the development of interprofessional collaboration. This impact of the stressors, on developing interprofessional collaboration, emerged as an unexpected outcome and will be explored further in sub-chapters 6a-d.

Further abstraction of the information provided in the concept spreadsheet and "Locating the categories" tool took place to later merge them to produce figure 5 "The Formation of Higher Order Categories" diagram which summarises the process of abstracting the findings from initial coding to core category stages, and ultimately creating building blocks for theory generation.

The content of these categories will be explored further in the next chapter along with the rest of the findings. However, ultimately the sub-categories were merged together in order to eventually identify a core category of "**Facilitating Interaction**".

The emergence of "**Facilitating Interaction**" reinforced Glaser and Holton's view (2004), that a core category is central to as many of the other categories as possible, occurring frequently in the data and creating a stable pattern that relates to the other variables.

When the data within the original two core categories were reviewed further it was noted that underlying all actions and decisions made by the participants in relation to interprofessional collaboration, was the impact that each had on "**Facilitating Interaction**" between them, at an interpersonal level. This underpinned the social processes articulated by the participants, whether these were at micro, meso or macro levels and led to the emergence of this as a core category.

The interactions were multiple and took place on a variety of different levels with colleagues within and outside of their immediate team. Whilst all the categories contributed to the creation and maintenance of interprofessional collaboration, the key aim of the participants appeared to be to maintain consistency through interacting with others. The

stability of this could be affected by other individuals, resources or strategic decisions. The significant impact of internal and external stressors on the participants, as individuals and as part of a social group when collaborating, will be explored further in sub-chapter 6c.

4.5.3 Writing memos

Whilst commenting that other qualitative approaches obtain further understanding of a topic through rich description, Glaser (1978) described memos as useful for conceptualising data, enabling the properties of categories to be developed so that hypotheses about connections between them may be presented, linking and locating them with others of relevance as a baseline for theoretical analysis through the process of abstraction. More simplistically, Lempert (2011) suggests they are a way of recording a conversation with oneself, with Robson (2002, p. 478) commenting that they are useful to “document anything that occurs to you during the project.”

The memos produced in this study provided insight into why actions had been undertaken and how concepts were defined, explored and populated, but they also encouraged reflexivity about my position within the study and the impact that my actions, and a priori knowledge had.

Following Charmaz’s (2014) lead, memos were produced without a formal structure, written flexibly in the format considered to be most appropriate at the time that ideas were unearthed. They made explicit actions, understandings and frustrations as they occurred in real time. They also included areas where further exploration was required, for example the impact of strategic decision making on individual’s responses to collaboration which led to the development of a separate category ***“Acknowledging Systemic Functions”***.

The memos were originally kept in chronological order, however, once these were reflected on, and previous ones reviewed, themes began to develop and I instead re-arranged the order of these, compiling the ones

that were considered to be of relevance to each other, for ease of further analysis to identify similarities or differences between concepts.

Charmaz (2014) described this as clustering; a technique useful in creating a visual image of how aspects of a phenomena connect with each other through the production of a map or chart, to creatively represent the relationships between findings.

Memos were compared to ponder over how the data collected would fit with what had already been worked on or whether it created a new direction of travel for theory generation and continued to be produced after the data collection stage was completed, following the attainment of theoretical saturation to ensure continued reflexivity.

4.5.4 Theoretical saturation

As concepts began to emerge during the simultaneous data collection and analysis, prompts were added to the interview guide that specifically focused on these areas to seek out additional information in subsequent interviews. Participants were sought that were able to contribute to this and to the further development and refinement of the categories (Charmaz 2011).

Whilst the analytical process allows for the emergence of new concepts, theoretical saturation occurs when no new issues are identified from the data, thereby allowing for the development of the properties of the categories (Glaser and Strauss 1967). For the purposes of this study, this was visualised as similar to the layers of an onion, in that new information built upon that previously obtained. This contributed holistically towards the emerging categories and towards developing the theory. Within figure 4, the dotted lines represent the fact that the boundaries between each service were permeable, with the findings shared between them as data were compared and contrasted.

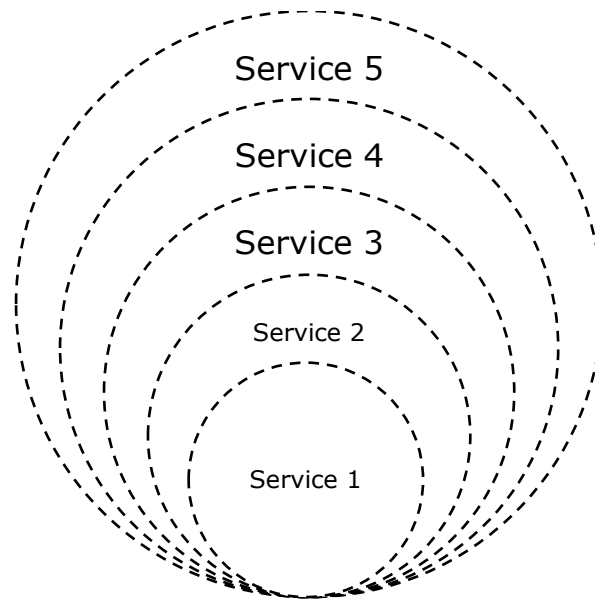


Figure 4 Layering the data to create theory

The constructed sub categories were used as points of reference during the interviews with the participants to seek out further explanatory information to clarify relationships, identify variation, distinguish and saturate and check hunches (Charmaz 2014) until no new properties or dimensions emerge (Holton 2007). Reinforcing this, Robson (2002, p. 199) reported that data continues to be collected until “further data collection appears to add little or nothing to what you have already learned.”

However, whilst Charmaz (2014) supports that theoretical saturation is the panacea that Grounded Theorists should aim for, she documents a line of discussion suggesting a lack of conclusiveness as to what the term theoretical saturation actually means. This is due to, what she perceives, is the risk of some researchers making a judgement that their categories are saturated when they may not be.

Instead Charmaz (2014) suggests returning to the data to see if new leads can be identified due to the risk of incomplete analysis, supporting the use of the phrase “theoretical sufficiency” by Dey instead (Charmaz 2014, p. 215), in order to undertake a more flexible approach to developing categories.

By the time the interviews from service five occurred, responses from the participants were repetitious with those previously obtained and with a minimal number of new concepts constructed. Those that did emerge, upon review of the contextual nature of these, could be attributed to the categories already developed.

As there was a lack of fresh directions to explore, the data was therefore considered rich and sufficient enough not to seek out further participants.

4.6 Summary

This chapter has sought to explain the processes of data collection and analysis in accordance with the requirements of a Constructivist Grounded Theory study, ensuring that the ethical requirements of undertaking research, but also those required by my professional code of conduct were maintained.

The processes of theoretical sampling, data collection and analysis that have been used in this study have been explained. Through applying these processes this has led to the development of two categories and a core category.

In chapter five interconnections between these categories will be articulated to demonstrate how they emerged from this process, to present the results from the interviews. The following chapter will therefore delve into the categories that emerged from these, providing a more detailed presentation of the findings. Further analysis of the findings and the positioning of the theory in relation to the phenomenon of interprofessional collaboration and contemporary literature is demonstrated within the sub-chapters in chapter six.

Chapter 5 - Presentation of the themes

Introduction

This study utilised grounded theorising to conceptualise the social processes leading to creating and sustaining interprofessional collaboration in intermediate care.

The previous chapters have introduced the study, identified the rationale for choosing the methodology, reviewed the literature pertaining to the phenomenon of interprofessional collaboration, and described the processes of data collection and analysis that the study undertook.

This chapter will present the themes that emerged as a result of participating in these processes. The findings are derived from semi-structured interviews with 24 participants and, for ease of reading, are reported in two sections:

1. The results obtained from collating the Team Circles exercise, which was completed by the participants at the start of the interviews, are summarised. These indicated that each participant's perception of their team composition differed significantly, thereby offering insight into the subjective realities of the participants' relationships with their colleagues.
2. This chapter will then present each of the categories, sub-categories and concepts in turn, providing an explanation of how abstraction of the initial coding led to their construction and eventually to the categories of "***Relating To Others***" and "***Acknowledging Systemic Functions***". The interconnectivity between these two categories resulted in the abstraction of a core category "***Facilitating Interaction***". This provided a structure for the social processes, communicated by the participants, that led to the creation of collaboration within this study and a rationale for the antecedents contributing to this.

The emergence of the concepts and categories subsequently led to the development of a theory within which *Dynamic Consistency* conceptualised the social processes used by the respective groups of individuals to maintain order and stability within their cultural settings. The purpose of the research questions within this study was to explore the experiences of individuals working in intermediate care settings to gain insight into how these interactions and ultimately interprofessional collaboration developed.

This chapter will present the findings obtained from exploring the research questions, with conceptualisation and category formation illustrated through the use of verbatim quotes from participant's transcripts. To provide examples of coding, an excerpt from an interview is included in Appendix 9.

First though, the following section will provide a summary of the "Team Circles" exercise used to encourage participants to reflect on the configuration of their teams.

5.1 Team circles: composition of the teams

Analysis of the pilot study interviews indicated that the participant's perceptions of the composition of the members of staff within their services varied depending on the need of the patient. This observation encouraged further exploration of individuals' perceptions of their intragroup structures, to ascertain whether this finding was unique of the pilot participants or whether it was replicable in other settings.

Upon completion of the Team Circle exercise, the diagram for each participant was collated. Attempts to present them visually proved to be too confusing due to the volume of professions documented by each participant, hence the decision to present them in tabular format. Whilst the full table of results is provided in Appendix 10, for illustration purposes, the results from IC 2 are provided here.

IC 2	Professions within the circle	Professions outside of the circle
OT 2	Community occupational therapy, dietician, physiotherapist, speech and language therapy	Single point of contact
OT 3	Administrative staff, allocator, dietician, falls prevention workers, physiotherapist, podiatrist, speech and language therapist , re-ablement staff, rehabilitation assistant, team leader	Community occupational therapy, community equipment stores, district nurses, GP, handy person's service, intermediate care beds, mental health teams, social services, specialist nurses, voluntary organisations
PT 4	Allocator, assistant practitioners, dietetic, manager, nurses, occupational therapist, physiotherapist , podiatrist, speech and language therapist	Community occupational therapy, district nurses, Multiple Sclerosis nurse, single point of contact, social worker, wheelchair services
N1	Administrative assistant, allocator, nurse, occupational therapist, physiotherapist , podiatrist, re-ablement assistant, receptionist, rehabilitation assistant, speech and language therapist	Did not put anyone on the outside of the circle

Table 1 – Collation of IC 2 Team Circle exercise

The professions and services documented by the participants were separated into whether they positioned them inside or outside of the

circle, indicating those they considered to be part of their in-group and others external to this.

For clarity of comparison, the professions and services have been listed in alphabetical order. To ensure confidentiality, the names of the services have been anonymised by removing any organisational specific details. Instead they have been given a generic descriptor of the type of team; for example, "Community Rehabilitation Team". This is used as opposed to the operational name of the team, which comprised the geographical location and therefore breached the anonymity of the data.

There was a lack of commonality in the results. Even though all participants were given the same instructions, the same diagram to work on, by the same person, who offered them all the same prompt if they needed one; there is a clear differentiation in who each of them perceives to be part of their service. As can be gleaned from the example of IC 2, **no two people, working in the same service, considered the composition of this to be identical to that of any of their colleagues from the same service.**

This reinforced the presence of multiple subjective realities perceived by the participants.

To demonstrate the extent of this variation those professions indicated in bold italics in the results table in Table 1 and in Appendix 10 are the ones which were mentioned by every participant interviewed from the same service. Whilst the lack of consistency of team composition from the first analysis of this data was evident, a decision was undertaken to explore the data further to ascertain whether a pattern emerged in relation to whom the participants considered to be the professions core to their service construction.

The outcome of this exercise is as follows:

Team names	Outcome of results
IC 1	No participants mentioned the same professions
IC 2	All participants mentioned physiotherapists and speech and language therapists
IC 3 and 4	All participants mentioned nurses, occupational therapists and physiotherapists
IC 5	All participants mentioned occupational therapists and physiotherapists

Table 2 Results of the collation of the Team Circles diagrams

The profession of physiotherapy was mentioned within four services, occupational therapy within three services and nursing within two services, with the exception of speech and language therapy within just one service. This reinforced the decision, taken at the start of the study, to concentrate on nursing, occupational therapy and physiotherapy professions for the purposes of data collection.

The findings from this exercise supported my a priori personal knowledge, but also that noted within the NSF for Older People (DH 2001a), that these were the core health professions for intermediate care services, alongside physicians. The responses from the participants concur with this, indicating consistency with the original developmental guidance for intermediate care services.

The findings from this exercise were also a sufficiently significant discovery to consider as they led to a reconsideration of the appropriateness of the terminology used to reflect the settings under exploration.

Whilst at the outset of the study the term “team” was considered a pertinent one, the continued relevance of this term was deliberated upon further due to the variability of the findings from this exercise. Recognising the lack of clarity in the contemporary literature of the term

“team” (Bleakley 2013), it was concluded, instead, more appropriate to use the phrase “social group” to encompass the different collectives that the participants were members of, bound together by unity, a shared identity or social category (Stets and Burke 2000).

This also recognised that the configuration of these were dynamic and in a state of flux, changing their membership dependent upon the circumstances, as group members engaged with each other.

The search for a means to achieve stability within this flux reinforced the value of **“Facilitating Interaction”** as contributing to their constant development and maintenance through the consistency of social processes. This was determined in comparing the data as, it became evident, that engaging in communication with other group members was perceived, by them, to encourage consensus and reinforce order and stability within their groups.

This will be demonstrated in the following section as the emergence of the categories is discussed in more detail.

5.2 Developing the categories

As expected from a qualitative study, the volume of data obtained was significant. As the data were collected, they were coded, conceptualised and categorised with the labelling and positioning of these undertaken flexibly, kept under review and modified where further data and comparison provided fresh insight.

Within this chapter and, for ease of reference, the inter-relationships between the emergent concepts and categories have been visually represented in figure 5. This demonstrates the five stage hierarchical process of abstraction undertaken within this study, but also the interconnections between the codes, concepts, sub-categories and categories with the emergence of the core category of **“Facilitating Interaction”** abstracted from these. When perusing this diagram, it is advised to read it from the bottom upwards to appreciate how the

emergent data, and subsequent analysis, has formed the baseline for the abstraction that followed.

Following on from figure 5, table 3 provides a brief comparative synopsis of the content of the core category and each of the categories and sub-categories. This is followed by a discussion of the emergent themes. To demonstrate transparency of the coding process the emergence of the concepts from the initial codes is documented in Appendix 11.

Within the content of this chapter, codes, concepts, categories and sub-categories, but also theoretical conceptualisations, are present within the text to illustrate the analysis. The labels applied to these abstracted components are indicated below using a different font to highlight their positioning.

A key to the presentation of these is offered below:

Codes – bold and italic

Concepts – bold, italic and underline

"Categories and sub-categories" – bold, italic and quotation marks

Theoretical conceptualisation – italic, and underline

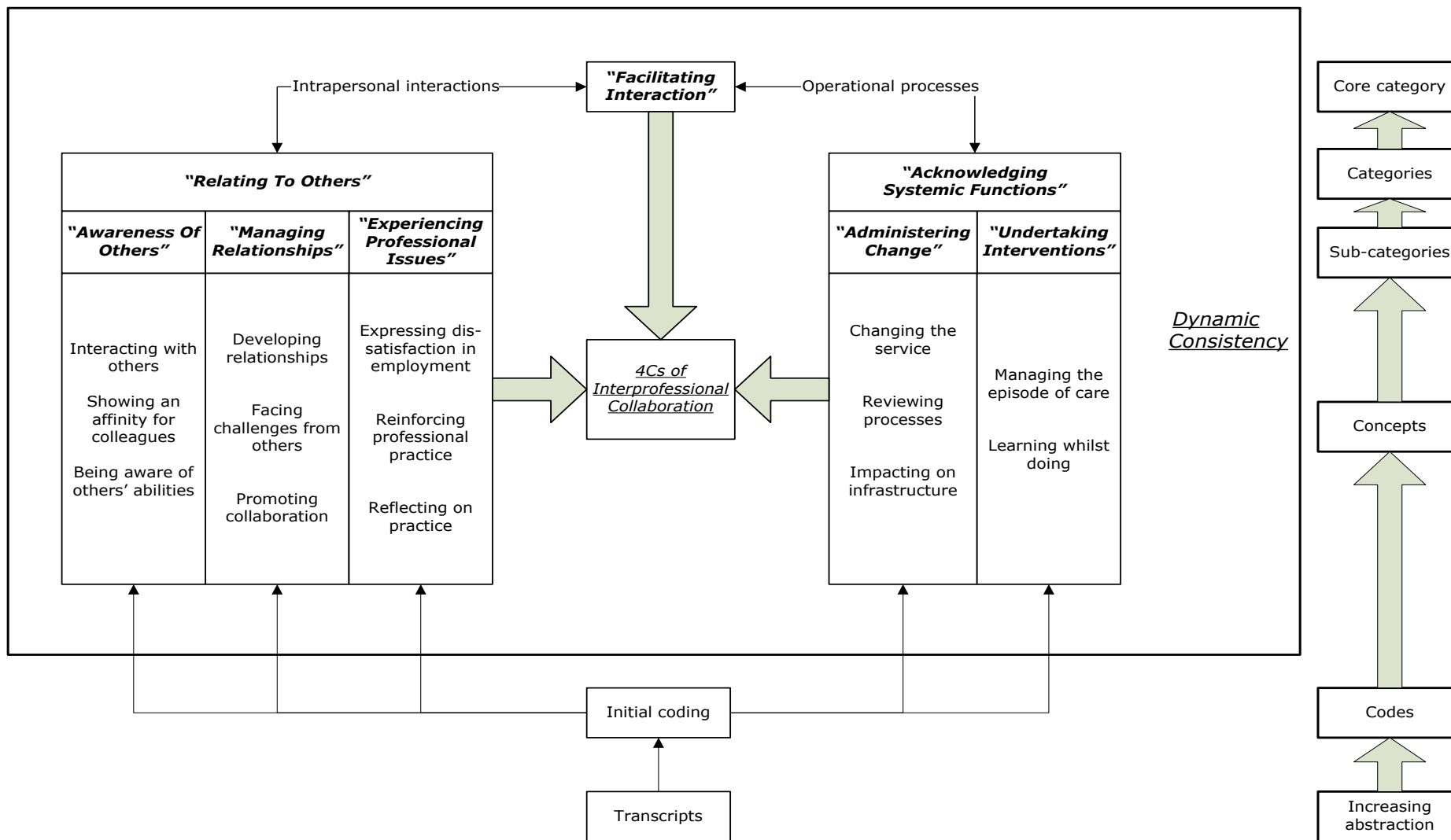


Figure 5 Formation of the higher order categories

Core category	“Facilitating Interaction”	
	The social processes undertaken by the participants to respond to interpersonal, operational and organisational circumstances so that interprofessional collaboration may be created and sustained.	
Categories	“Relating To Others”	“Acknowledging Systemic Functions”
	Emphasis placed by the participants on their relationships with their colleagues and their mutual commitment to each other.	The impact of the strategic and administrative components of organisations on how individuals collaborated.
Sub-categories	“Awareness Of Others”	“Administering Change”
	Recognising, and being mindful of the needs, skills, knowledge and competencies of those with whom the participants worked. This contributed to the development of interpersonal relationships and working across traditional professional boundaries.	The frequency and significance of change impacting on the wellbeing of the participants as they operationalised the changes required of them. The recognition that change is the status quo in modern day health care services.
	“Managing Relationships”	“Undertaking Interventions”
	The social processes undertaken to create and maintain inter-professional relationships.	The shared clinical frameworks and role of situated learning in the workplace contributed to an increased emphasis on collaborative practice.
	“Experiencing Professional Issues”	
	Concern expressed by the participants of the stressors they faced when undertaking their occupational role and the potential impact of these on them, both personally and professionally.	

Table 3 – Summary of the categories and sub-categories

5.2.1 “Facilitating Interaction”

Earlier in this chapter the reader was advised to consider the Formation of Higher Order categories figure from the bottom upwards to demonstrate the process of abstraction leading to the development of “**Facilitating Interaction**” as the core category. The rest of this chapter will now work in reverse from this point, unravelling how this was determined from the emergent data.

My overarching aim of the study was to explore the meanings that professionals placed on their experiences of working within intermediate care teams, and how they construct and re-construct this reality; ascertaining how interpersonal relationships and interprofessional collaboration is created and sustained within those services.

I have previously suggested the use of the term social group as an alternative to that of “team”, following insight into the inconsistent perception of team composition. However, realistically I recognise that terminology is irrelevant if individuals lack the skills and abilities to work together in a collaborative way hence the value in this study of exploring this further.

Upon examining the data, “**Facilitating Interaction**” emerged as the core category approximately half way through the total number of interviews undertaken. Participants utilised coping strategies as they actively communicated and developed their interpersonal relationships with others. The strength of “**Facilitating Interaction**” was demonstrably evident in every interview, with every participant, and was identified by them as of vital importance in order to enable them to support each other, to work together, but also to cope personally and professionally within the current climate of service provision and change endemic within the NHS.

In determining an appropriate label for the core category, the term “facilitating” was not my first choice. Alternative options for phraseology

included “undertaking interaction” and “empowering interaction”. However, upon interpretation of the meanings applied by the participants these were disregarded. The term “facilitating”, with its emphasis on simplifying, smoothing and making possible, was instead considered a more appropriate fit to represent the pro-active processes articulated by the participants as they interact with others. All of the sub-categories and categories that emerged from the data contributed to the establishment of this.

The following sections will demonstrate how the core category is grounded in the data. The codes and concepts abstracted from the initial coding were positioned into two categories “**Relating To Others**” and “**Acknowledging Systemic Functions**” that subsequently contributed to the emergence of “**Facilitating Interaction**”.

During an earlier stage of analysis, the two categories “**Relating To Others**” and “**Acknowledging Systemic Functions**” were originally merged together as “**Impacting On Interprofessional Relations**”. However, the unanticipated and significant impact on the evolution of interprofessional collaboration that was generated in response to stressors from the strategic and administrative elements of organisations had not been appreciated by myself at that stage.

Due to the impact of these stressors on individual’s personal and professional wellbeing, the category of “**Impacting On Interprofessional Relations**” was re-labelled and was separated into the two distinct categories noted above so that the interconnectivity of each could be explored in more detail. The data within “**Acknowledging Systemic Functions**” is a significant inclusion as the connections between the two categories create a holistic overview of the social situations faced by the participants.

I considered that the term “**Facilitating Interaction**” is therefore indicative of the social processes undertaken by the participants to

respond to events within their contextual settings, managing them within the parameters of expected practice and ensuring consistency of service provision. This was achieved through maintaining open lines of communication and developing positive and effective interpersonal relationships between colleagues of any professional background.

5.2.2 Constructing “Relating To Others”

From the interview responses of the participants I interpreted the responses as showing that they placed value on these strong and positive relationship dynamics. **“Relating To Others”** therefore emerged as of value in the early stages of data collection. This emphasised how participants described their interactions between themselves and their colleagues, having an understanding and an appreciation of those with whom they worked closely, at an individual and collective level.

I interpreted this to indicate that participants had a meaningful commitment to supporting each other personally, when **“Relating To Others”** and to professionally manage the situations they faced, which the participants reported did, on occasions, lead to them **Expressing dissatisfaction in their role** to others.

Positive relationships were described between participants and their immediate peers and other colleagues within their networks. However, the relationships with those perceived to be in positions of power in strategic and commissioning roles were expressed using more negative undertones, indicating the presence of barriers. This will be explored later in this chapter.

Following analysis of the data, within the category of **“Relating To Others”** three sub-categories were identified. These are shown below along with the concepts contributing to their development. Each of the sub-categories and their concepts will now be considered in turn in sections 5.2.2.1 to 5.2.2.3.



Figure 6 Sub-categories and concepts of “Relating to Others”

5.2.2.1 “Awareness Of Others”

When comparing the data, the social and affective characteristics present led to me interpreting these as **“Awareness Of Others”**. This sub-category was derived from the recognition that participants were particularly mindful of the wellbeing of peers with whom they came into contact. In addition, professionally, through the development of blurred boundary working, the participants realised they had acquired a greater understanding of each other’s roles and an appreciation of the abilities, skills, knowledge and competencies of each individual. They perceived this as contributing to developing integrated working.

“Because when you are looking at how far we have come and you are looking at how far else we can go, we have got some absolutely fantastic staff with lots and lots of skills that we could carry on working more and more together” PT 4, transcript line numbers 379-383

The three concepts to the sub-category **“Awareness Of Others”** will now be explored:

5.2.2.1a Interacting with others

Participants demonstrated insight into the value of communicating with their colleagues, **Talking to others**, and this was a recurring theme that I noted in all the participant's transcripts.

"I think we are really good at talking our problems out like if there is a difficult patient we have a lot of informal supervision and discussion about them really. I tend to go to the physios and she will tell me what she thinks, I will tell her what I think and we will come to a decision talking it out. Same with the nurses and any professional" OT 6, transcript line numbers 108-113.

The quote above is indicative of that obtained from all of the participants and represented the wide ranging and extensive nature of how participants communicated with each other. Comparing the responses, this was typified by a willingness to ensure that the sharing of information, knowledge or skills took place as smoothly as possible to attain consensus.

Indeed, within the data there were no reports of individuals deliberately setting out to be obstructive as they communicated with others. Rather than the interactions being profession specific, what became apparent to me was how participants considered they were able to approach colleagues from any profession to seek information, thereby suggesting the suppleness of professional boundaries in terms of these interpersonal communications.

This notion of learning from each other became further apparent from reports of past experiences of where successful interactions had taken place.

"Lots of storytelling goes on that shares that, and it its interesting and people say I remember you saying such and such. I've done

that for my client and it worked really well” OT 1, transcript line numbers 186-188.

Initially I had labelled ***Interacting with others*** as ***Exchanging information***, coded as such to reflect the sharing of information between colleagues. However, due to the continual emergence of data relating to the two way nature of the exchange, the different styles of communication and the variety of situations in which the participants were ***“Relating To Others”***, this was perceived to be too restrictive a concept. Rather than risk constraining the data, I re-labelled it ***Interacting with others*** to encompass the extent of the different methods and styles.

This concept was applicable for personal as well as professional interactions. A recurring theme was the acknowledgement by participants of working generically. In doing so, participants implied they had overcome any preconceived professional boundary or identity issues, reporting that they would approach who they considered to be the person most able to assist them through ***Networking with others***. Other codes used to reflect these behaviours included ***Sharing information***, ***Engaging with others*** and ***Reflecting on actions***.

“I have worked in this team so long it just comes naturally to share and ask advice from a therapy colleague” N 6, transcript line numbers 66-67

“It doesn’t matter what discipline of staff you are, we all meet together and discuss things” N 2, transcript line numbers 168-169

Whilst participants recognised that they retained membership of their professional group, the pronoun “we” was used in different ways, depending on the context, not just to signify their professional identity but also to categorise a social, collective identity, inclusive of colleagues from different professions.

This contrasted with the meaning applied in Green's study (2013, p. 37) whereby he indicated that the pronoun "we" was used in relation to a professional group identity. I would therefore suggest that the strength of the interprofessional relationships that this use of phrase indicated was highly significant in demonstrating the generation of interprofessional collaboration within the services in this study.

Within the empirical literature, there is limited documentation of how such interpersonal and interprofessional relationships are developed within intermediate care and to reach this stage of acceptance the participants all reported a lack of formal development time, provided by their organisation, to contribute to this.

Instead, participants reported becoming more attentive to and increasing their "**Awareness Of Others**" through participation in team meetings, or **Interacting with others**. They reported undertaking informal information gathering sessions in order to actively develop networks, which upon reflection, were perceived to assist with collaborative working.

"I think on a day to day basis if I am not sure about anything then I will go to whoever is involved with that person" OT 6, transcript line numbers 166-167

"There is always someone here to go to. It doesn't have to be a formal supervision so I think everybody here is approachable to do that with whatever discipline so that's good" OT 4, transcript line number 141-143

This mutual support acknowledged by the participants, both individually and collectively, reinforced how **Interacting with others** was particularly relevant as it reflected how relationships had developed through the ongoing process of interpersonal contact with individuals based on these relationships in contrast to professional groupings.

5.2.2.1b Showing an affinity for colleagues

Whilst the previous section described how the processes of communication led to the construction of ***Interacting with others***, this concept relates to the empathetic, affective elements of relationships that have developed from doing so.

To develop relationships, participants highlighted the presence of empathy, trust, respect and concern for others as essential. These were recurring themes across all services characterised by codes such as ***Being kind to others***, and ***Caring for others***.

"We have to be as kind to our colleagues and the people we network with as we do our patients and I think we have got that"
OT 1, transcript line numbers 223-225.

I labelled the concept ***Showing an affinity for colleagues*** as such to reflect a sense of togetherness and kinship between individuals. This became increasingly apparent due to the reports by participants of the stressors they faced on a daily basis. Participants reported that they had developed a number of coping strategies to manage these, often relying on colleagues to help with this. This created opportunities for communication as assistance was offered and support sought through ***Talking to others, Expressing feelings*** and ***Sharing the load***.

The following quote is indicative of this, where a participant has been offered assistance by a non-supervisory colleague to cope with the demands of their workload.

"Erm, I think sort of when I have gone and said that I really feel a bit stressed this week, I feel that I have got too much on and then somebody has actually gone through my work with me and said, perhaps so and so can do that and then helped me see a way through the things" OT 4, transcript line numbers 136-140.

Historically, within the literature, co-location of services, whereby individuals share an office, has been considered to enhance interaction between colleagues, however the nature of community based practice indicative of intermediate care services can make this difficult to achieve "**Facilitating Interaction**". Participants reported that the vast majority of their day was spent outside of the office environment with patients in their own homes, therefore not in immediate face to face contact with their colleagues.

Interactions with others were therefore, not always easy to undertake, predominantly reliant on telephone calls or emails. Recognising this, some participants reported that, when they were in the office, they proactively sought out colleagues, demonstrating **Showing an affinity for colleagues** to ensure others felt supported.

"I make sure that I go around and speak to everyone and make sure things are ok, and that I am supporting them. Erm, when you are out in the community you are on your own" PT 1, transcript line numbers 218-221.

In contrast to the supposition within some elements of the extant literature that interpersonal relationships and integrated practice would automatically develop when individuals worked together, incidents such as this reinforced evidence in this study of participants being proactive in **Caring for others, Valuing others, Considering other's perceptions** and **Demonstrating empathy**.

Locating oneself so close to colleagues in this way was therefore considered to be a positive factor in establishing interpersonal relationships and an affinity for others. Within the data this did not just apply to existing colleagues, but the act of **Demonstrating empathy** reflected how support was also offered in relation to those joining an already established service.

"Again, it is just trust and understanding, to build relationships really. It's hard when people first come in the team though" N 2, transcript line numbers 161-162.

Participants, encouragingly, reported assisting new members of staff to increase their awareness of the expected operational parameters of practice. They perceived that this contributed to their integration as a group member through the process of socialisation into the culture of the service, ensuring consistency in approaches through a continuation of the accepted ways of working.

5.2.2.1c Being aware of others' abilities

This concept emerged to assist with positioning participants in relation to others. I labelled it **Being aware of others' abilities** to recognise the participants' understanding of the diversity of skills, paradigms and perspectives of the different group members. This reinforced the concept of permeable traditional professional boundaries, but also offered clarification of how participants considered that they fit with others.

"I think ultimately the other members of this core team need to know what I do and I need to be clear what it is that they can do. If we start from that point that there are certain things that only I can do then that absolutely sits with me. Next to that comes what is it that I can't do and you have to have that understanding as well" PT 5 transcript line numbers 90-94.

The codes **Understanding each other's roles** and **Recognising others' skills** were examples of representing the creation of this mutual appreciation, which was perceived to contribute to the facilitation of consistency in approach and shared competencies through consensus.

Based on the emergent data attributed to this sub-category it was therefore considered that participants had demonstrated that, within their contexts, interprofessional collaboration was enabled through **Being**

aware of others' abilities, Showing an affinity for colleagues whilst **Interacting with others.**

5.2.2.2 "Managing Relationships"

This sub-category was interpreted to indicate the recognition of the social processes that were undertaken to form interprofessional relationships. It differs from the previous sub-category which pertained to the affective aspect of relationships.

At the outset of the data analysis, **"Managing Relationships"** was identified as a core factor in enabling effective collaboration, and I initially considered it a category in its own right. However, as more data were obtained, and further analysis took place, this was determined to be too simplistic an approach. Underlying the information provided by the participants was the process by which individuals were **Developing relationships** and **"Facilitating Interaction"** to manage situations inside and outside of their control. **"Managing Relationships"** was therefore repositioned to become a sub-category of **"Relating To Others"**.

From the preliminary literature review, empirical studies had suggested that not all interprofessional relationships are positive ones and within the context of this sub-category, **Facing challenge from others** was reported as present, predominantly from colleagues external to the operational services. This contrasted with a reported lack of internal dysfunctional communications between colleagues of the same social group. The stability of these internal communications was therefore constructed as encouraging individuals to seek consensus and unity and led to the development of the concept **Promoting collaboration.**

This applied to relationships both within and external to their service through **Working in conjunction with others.** This was a code that had developed from the codes **Working well together** and **Working with**

partners, which, upon reflection, both contained similar data and therefore were merged to reflect the process of working alongside colleagues.

There were three concepts within "**Managing Relationships**" identified, each of which will be considered below:

5.2.2.2a Developing relationships

During the interviews the participants articulated how they networked with their colleagues to actively develop interpersonal relationships and to engage with others to work in a more integrated and consistent way across professional and service boundaries. This concept therefore reflected the social processes they took to achieve this.

Organisationally, it may be suggested to be good practice to allow staff to have developmental opportunities to assist with embedding change. What I interpreted from the data, however, was the limited formal opportunity to do so within the services in this study. Instead, it was perceived by the participants that this was developed through communicating on an informal basis, **Getting together** and **Building rapport**.

"as an overall team building, there isn't anything that we generally do to build the team. I mean at lunchtime we are all very social, we talk and that kinds of builds rapport, but nothing specifically." PT 6, transcript numbers 145-147.

Whilst these were opportunities to interact with others, they also offered the chance to appreciate the different characteristics of individuals. This was coded as **Recognising how people work differently**, with participants reporting the acceptance of the diversity of these during the process of **Developing relationships**.

"Some people are proactive and very different and others just prefer to go with the flow. I think you can find people of your own nature that you can talk to" OT 8, transcript line numbers 315-317.

This reinforced the nature of autonomy and was suggested to allow participants to maintain their individuality, through **Respecting diversity**. My perception of the data is that it implied that this was acceptable as long as individuals still operated within the range of standards expected by the group. In terms of negative behaviours, there was no incident offered, within the interviews, of participants working contrary to the expected norm, therefore it was not possible to glean the impact that such behaviour would have on individuals on a personal or professional basis.

5.2.2.2b Facing challenges from others

During the course of the interviews positive reports of the interpersonal relationships between participants was therefore clearly evident.

However, the **Facing challenges from others** concept emerged due to the recognition that at times relationships between the participants and their colleagues could be strained, particularly where stressors were prevalent.

This led one participant to use the analogy of a marriage to describe these relationships.

"On stressful days, we all, you know, going to work is like a marriage, we work together and yes it has got a little bit heated, but in a healthy nature" N 5, transcript line numbers 344-346.

The concept of interprofessional collaboration, as described in the context of a marriage, is not one noted in any of the empirical literature reviewed for the purposes of this study. However, it is possible to appreciate this analogy due to the intensity of interactions and affinity for others demonstrated by the participants during the interviews. This reinforced the strength of the participants' interpersonal relationships with each other, but also how they put coping strategies in place to overcome any difficulties.

Unlike other empirical studies noted in the preliminary literature review, which suggested a presence of conflict within teams, the participants in this study reported rare occasions where they considered they were ***Facing challenges from others*** from those within their social group. Therefore, due to the emotive definitions of the term "conflict" as relating to turf wars or fights between parties, the use of this within the literature was reviewed. Unlike in many extant studies, I considered it not to be reflective of the relationships within this study as there was no evidence from participants that this occurred significantly within their services. I therefore instead perceived the term disharmony was to be more characteristic of the responses to represent situations of tension or unrest that were mentioned during the interviews between in-group members.

Participants suggested instead that they discussed any state of disharmony between themselves to put strategies in place to achieve an outcome of consensus.

"if you have a difference of opinion, seeing how it can be managed, seeing which one is more feasible, which is more realistic and obviously discussing it with the patient as well" N4, transcript line numbers 161-164.

This use of discussion as a coping strategy was reported to be present within all the services in this study and was considered a contributory factor in resolving difficulties to manage these situations through the process of interacting with colleagues to achieve consensus. This was aided by the strength of the interpersonal relationships developed between the in-group members.

"We have got those relationships and it's never going to turn into confrontation" OT 6, transcript line numbers 126-127.

Upon comparing the data, an interesting finding from all the services was that the participants highlighted that managing the effects of disharmony

was time consuming and impacted on the resources available to undertake their operational role. Due to the demands on them professionally, the dysfunction this created was therefore perceived by the participants to have a wider impact on their overall performance. To manage this, participants reported taking time, which was coded as ***Making time for discussion*** to proactively resolve any issues that arose that may impact on how the team functions.

"Generally the team works really well and we all work well together. If there are any problems then we will all discuss it together within the team" PT 6, transcript line numbers 297-299.

In doing so, it may be perceived that the intent of this discussion was to reach agreement in how to manage specific situations.

Although situations of disharmony were reported as infrequent, it was noted that issues ***Affecting relationships*** and ***Putting barriers up*** were more likely to occur at times of stress or when there were pressures of high demand and limited capacity for the service.

On these occasions participants stated they referred back to their personal knowledge of each individual, ***Engaging with others*** and ***Listening to each other***, both codes identified within ***"Awareness of others"***, to reflect on how people would normally present. They suggested talking to colleagues to offer support in managing the situation should difficulties present. This reinforced the extent of cohesion between the concepts, but also the individual group members.

"I think everyone is very supportive of each other. There are always times in the team when due to sickness and that kind of thing people do get stressed but it is never because we are not working as a team but more because of workload and resources" PT 7, transcript line numbers 354-357

This was interpreted as reinforcing a proactive approach to the management of interpersonal relationships. The concept of ***Facing challenges from others*** may be perceived to impact on the effectiveness of these relationships, however within this study this concept was not necessarily always perceived as a negative issue. It was instead reported that challenge did allow the opportunity to review how individuals worked.

"I think in everything we will have disagreements, different opinions but I think in everything that helps the discussion; I don't think that is anything you know. It is getting people to look at the different ways that they work to as to how they work. And I find the majority of time it is still respected" N 5, transcript line numbers 340-344.

Reflecting on practice in this way, I interpreted this as suggesting that coping strategies were put in place to manage dysfunctional situations and disharmony between individuals. A comparison of the data between the services, and also individuals, suggested the aim was to achieve a continuation of consistency for how the service operated, creating a sense of order and stability.

The desire to achieve this appeared to be strong between the participants suggesting that, due to the demands they perceived to be placed on them, participants did not relish any desire to fight between themselves, instead seeking a peaceful co-existence.

5.2.2.2c Promoting collaboration

Whilst the participants all promoted the value of collaborative working, they found this phenomenon difficult to define. Collaborative practice was considered to be such an integrated part of their style of working that the participants worked in this way habitually.

"So actually, I think that this intermediate care team was quite trail blazing in working together, but ever so quietly. You know I hear

lots of other teams shouting about what they do and I just think 'God we have always done that'". PT 5, transcript line numbers 142-145.

Evidence for how **Promoting collaboration** was achieved was assisted by the coding of data indicating ***Working in conjunction with others*** and ***Working in an integrated way***. Through the development of networks and agreed parameters for practice, this contributed to the creation of consistency in approaches. To achieve this, the participants articulated behaviours interpreted as ***Being proactive*** in ***Sharing skills*** and ***Enjoying working together***.

"I think the structure works because people have done their job and they see the value of others and they work together and make it work. Not because the structure was put in and you were told to do it" PT 4, transcript line numbers 203-205.

The concept, within political rhetoric, of bringing people together and expecting them to work in an integrated way may be perceived as a flawed one, based on the findings of this study, which reinforced that interprofessional collaboration had not occurred automatically. Integrated practice may be a desired state, but this required a practical and proactive approach from operational staff to support the development of it.

"It's about working together and respecting each other and not maybe fall out with that person because they haven't agreed with your opinion. There have been healthy debates but I have never felt threatened or undermined in any of the professional decisions I have made" N 5, transcript line numbers 351-354.

As noted previously, although participants indicated they collaborated with their colleagues, characteristic of their responses was an inability to summarise how they did so. This was an intriguing concept coded as ***Collaborating unconsciously*** to reflect the fact that once a state of

collaboration was achieved it had become a tacit way of working, undertaken within the agreed parameters for the service.

"Do you know what, I honestly think that we do it so automatically, so freely that I don't necessarily think that we have to think about it" PT 5, transcript line numbers 80-81.

The concept of **Promoting collaboration** was therefore interpreted to represent the proactive and continued maintenance of this way of working. However, in accordance with the results of the Team Circles exercise, the findings suggest that interprofessional collaboration is a state that is negotiated based on individual circumstances, dependent upon the situation in which it is required, and the individuals participating in it, who form the social group for that context.

Due to the variety of factors affecting it, interprofessional collaboration therefore remains in a state of flux, operating within defined parameters and unique to each situation. Whilst this can offer consensus within the situation, it can also provide learning opportunities for those providing interventions as individuals are learning from each other.

"This is the first team that I have worked in where we work closely like that so I have, in the five years coming up, learnt a great deal" N5, transcript line numbers 235-236.

5.2.2.3 "Experiencing Professional Issues"

During the course of the interviews I heard recurring accounts of the demands faced by the participants and the impact that, what they perceived to be stressors, had on them in not just a personal, but also a professional capacity.

From the early interviews this had emerged as a sub-category entitled "**Professionalism**", however I later re-labelled it "**Experiencing professional issues**" as more data emerged, was coded and compared. By reflecting on the responses in relation to the original coding it became

clearer to me that the points being made by the participants did not relate to issues about the construction of their professional identity, or profession, but more concern about their ability to undertake their occupational role in a way that they considered was conducive with the professional standards they had set themselves, but also those set by their regulatory bodies.

In response to the stressors they perceived were affecting them the participants recounted that they were **Reflecting on practice**, **Reinforcing professional practice** and **Expressing dissatisfaction in their employment** to manage the impact of these on the performance of their role.

The reader may question the relevance of these to interprofessional collaboration, however, when I considered the emergent data holistically; the concepts provided evidence of stressors within the environment of the workplace which encouraged participants to put in place mutually agreed coping strategies to manage them, thereby suggesting the creation of allegiance and kinship through ***"Relating To Others"***.

5.2.2.3a Expressing dis-satisfaction in employment

Whilst I reflected that, on the whole, the participants' responses were favourable about their services, their roles within them and their relationships with their immediate colleagues, a greater sense of unhappiness was articulated by them in relation to their strategic managers, organisations and commissioners. Originally this was labelled **Expressing dissatisfaction in role** but due to the wider ranging elements that emerged; this was subsequently changed to **Expressing dissatisfaction in employment** to take into consideration organisational and systemic factors.

This reflected the interpretation that many participants expressed unhappiness about what was required of them, in their operational roles, considering that decisions were made that placed increasing pressures on

them to perform with limited resources and frequent changes affecting how the service operated.

"The pressure has increased and definitely got worse. So distant, from a sort of understanding and caring point of view. But actually very close and claustrophobic from a micro-managing point of view of how to do your job when you don't really know what I am doing and the pressures I am under. I feel restricted from being able to do my job and being able to do the clinical work that is so desperate to be done out there" OT 8 transcript line numbers 291-297

Coded as **Feeling under pressure, Deteriorating situation, Feeling isolated, Impacting psychologically, Lacking support from the organisation** and **Expressing concern**, this situation was an example of some of the stressors faced by participants.

Whilst the stressors arising from this situation were reported as having a significant impact on this individual's psychological health and wellbeing, other participants, in similar situations, stated that they benefited from the mutual support and awareness of their colleagues which assisted them to cope in such circumstances. This has already been articulated within the sub-categories of **"Awareness Of Others"** and **"Managing Relationships"**.

Frequency of change was another stressor and one that was perceived as a constant feature for all teams. How effectively this was managed varied. Codes related to this included **Having no choice** and **Lacking information about change** about what has been proposed for them.

"The actual change process, I believe, was quite poorly managed just from our point of view in the team we were in at the time. Whether other teams got better information from their team leaders, but we were just very much told from the 1st November this is happening" PT 7, transcript line numbers 178-181.

The nature of the information shared by the participants in relation to this concept led to the presence of the most negative codes of the study that were used. As well as leading to participants **Feeling isolated, Feeling disillusioned** and **Fearing for the Future**, there were also reports within IC 1 and IC 5 that due to their service's re-design, participants highlighted that they were **Lacking morale. Removing staff** from the service, but with the demand from the service still remaining, led to **Feeling under pressure** by those left within the service.

"You can imagine morale at the moment... is not good. Our team leader has now gone. She is working in the pilot integrated care team. And they are taking our staff to help them" N 6, transcript line numbers 169-171

What became apparent was the perception of the participants that they were unable to prevent such incidents occurring and **Feeling unappreciated**. As a result there was evidence of a perceived relationship chasm between operational staff and strategic management.

"We are minions, don't answer back, it is entirely different. You are not always meant to feel valued from above. There is a chasm between us..." N 6, transcript line numbers 180 – 182

Responses such as this indicated the presence of **Working in divisions**, which led to difficulties that, even with the goodwill of staff, were problematic to overcome, and perceived to be outside of their control to influence.

The responses offered by the participants, which characterised this concept, were difficult to hear and contributed to me feeling empathy towards them. For the purposes of this study though, they were useful to have documented as they were a significant contrast to the interpersonal relationships articulated between the participants and their peers.

On reflection, a positive aspect of this is that whilst these difficult situations impacted on the relationship between participants and those at a strategic level, the unexpected implication construed from this information is that this situation assisted in creating and sustaining interprofessional collaboration at an operational level as participants united in response to manage these issues.

5.2.2.3b Reinforcing professional practice

In spite of the dissatisfaction with the strategic tiers within organisations, and the demands on the services, participants expressed strongly the need to maintain their professional standards of practice. From a clinical governance perspective, they recognised this as important to maintain consistency, but also, realistically, for preservation of their own professional registration.

This concept therefore indicated the need for me to recognise the integrated approach that participants took to maintaining their professional requirements. This took into consideration the habitual behaviour, values and norms required to become an accepted member of the social group, or wider team depending on the context of the situation.

Acceptance as a fully-fledged member of the group was coded as ***Transitioning to integration*** to reflect the developmental journey undertaken, with participants at different stages of integrated practice.

"It is absolutely a mind-set that you have to get into and I think it takes time and I think we are still on that journey to get there. We are not fully there but that's where we are headed and I think you have got to have that vision" N 1, transcript line numbers 136-139

Even though the presence of interprofessional collaboration was evident from all participants' responses, there were occasions where this did not sit comfortably with some. OT 4, a newly qualified therapist, admitted to feeling frustrated at times, when she considered that other staff members

were taking on her traditional professional role and considered that she needed to retain as much of this as possible.

To reflect this consideration of professional tasks I coded this as **Maintaining professional responsibility**, but also **Being accountable** and **Protecting own roles**.

"I think there was quite a lot going on about blurred boundaries and things in the teams so it was that point about where we as OTs, because I think we are quite a small voice, that we had to stick up for our own profession really, and erm, yes we all work together but occasionally you do need to say 'this is my role'" OT 4, transcript line numbers 32-36.

OT 4 had only been qualified for a few months, therefore her strength of uni-professional identity was understandable; resistance to collaboration (Suter et al 2009) may present, at times, in others also and result from the demonstration of "professional preciousness". This was labelled as such to reflect a desire to preserve roles and responsibilities perceived to be the domain of that profession.

5.2.2.3c Reflecting on practice

Continuing the theme of working as a professional, the concept **Reflecting on practice** was construed to relate to the participants' perception of their own professional practice within the wider context of the service and how they collaborate with others.

This concept illustrated the recognition by the participants of the difference in role required to work in an intermediate care service compared to other settings. This was assisted through them **Realising limitations**, and **Reflecting on actions**.

"I wouldn't say that when I first came here I could do everything but you know I have signed off those competencies. There have been quite a lot of nursing role that I do now that I certainly

wouldn't do in a hospital, but we do it because we are in the community" OT 4, transcript line numbers 296-300

Through situated learning and the sharing of skills, knowledge and competencies, the existing core skills of the professionals were enhanced, offering an opportunity to reflect on **Knowing their own competencies**.

"we do work within blurred boundaries so whilst I may have lost a few of my OT specific skills I have picked up nursing and physiotherapy type skills" OT 7, transcript line numbers 47-49

By sharing knowledge, skills and competencies across permeable boundaries it was suggested that a flatter hierarchical structure operated within the services **Offering professional equity** and consistency.

"We do try to, you know, this is what the nurses have to do, this is what the physios have to do, this is what the OTs have to do. I think we are all equal" N2, transcript line numbers 169-171

This enhancement of integration also helped to develop coping strategies to overcome stressors and led to the emergence of the code **Demonstrating professional maturity**, as participants displayed a desire to maintain practice through preserving open lines of communication between different colleagues.

"I mean at the moment I really like this team and it works really well together. Everybody does talk, so it would be useful to do some team bonding and things, but I think the team works quite well anyway. I have worked in other teams before where it has not worked quite so well or where people haven't been quite as friendly or collaborative" PT 6, transcript line numbers 149-153

I considered that this was applicable both personally and professionally as participants reflected that they needed to feel confident in their own clinical abilities before they could take on the role of other professions,

Working across professional boundaries, to gain an understanding of others' roles in order to assist with this.

"I mean in terms of here and the role we do, it is a lot more of a blurred role between physio, OT and things like that, so there is a lot of things here that I am learning that we never learnt at school"

PT 6, transcript line numbers 34-36

This comment reinforced others made that had supported the value of situated learning in enhancing shared competencies, skills and knowledge.

This section has summarised the findings that were attributed within the category **"Relating To Others"** and their contribution to developing interpersonal relationships. The following section will expand on the findings that were abstracted to develop the second category of **"Acknowledging Systemic Functions"**, recognising the unexpected impact that these had on creating interprofessional collaboration.

5.2.3 "Acknowledging Systemic Functions"

During the course of the interviews a recurring theme emerged that related to the impact that decisions made at a strategic level had on the staff working operationally. Decisions cascaded downwards from higher management were suggested to have a cumulative effect on participants as they stated they were expected to operationalise them, often with minimal guidance.

This highlighted a need to explore these effects further, as the impact of stressors and adversity on promoting collaboration had not originally been anticipated. When initially analysing the data, service re-design had been included as a sub-category under **"Relating To Others"** and labelled as **"Operational Processes"**. The influence and the relevance of it became more evident during the analysis of further interviews as participants indicated the undue pressure it placed on them. Therefore, it was

concluded that it warranted developing further as a category in its own right that was labelled **"Acknowledging Systemic Functions"**.

When I was considering how to label this category the term "organisational" was originally mooted instead of "systemic" however it was determined that instead the latter encompassed the strategic, managerial and environmental components of organisations and the effect that these have on operational functions and interactions. The term 'systemic' was therefore considered to be a more appropriate fit.

The inter-relationships between **"Relating To Others"** and **"Acknowledging Systemic Functions"** were perceived to provide a holistic overview of the presence of interprofessional collaboration within the teams in this study. It is therefore maintained that neither category can be considered in isolation, within this study, without recognising the significance of the presence of the other, reinforcing consideration of the combined effect of interpersonal and systemic factors.

Within the category of **"Acknowledging Systemic Functions"** two sub-categories were identified and these will be explored further below.

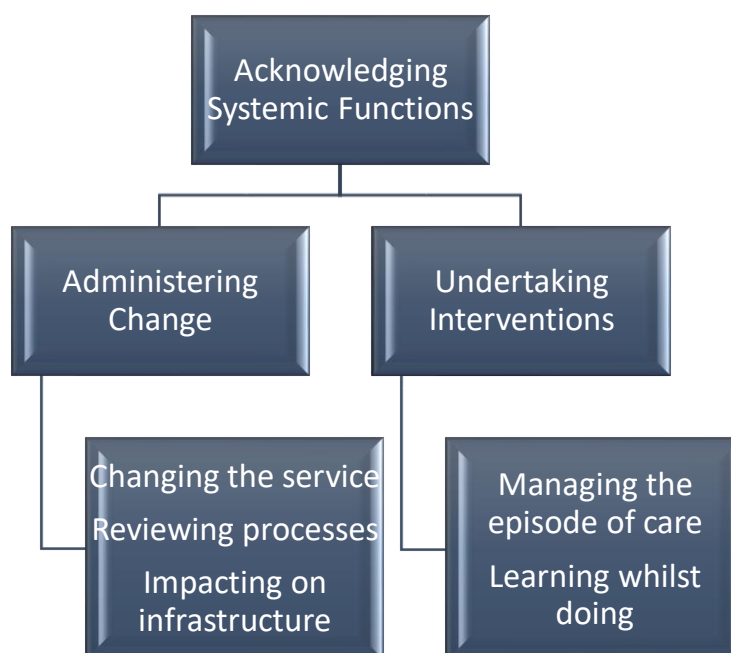


Figure 7 Sub-categories and concepts of "Acknowledging Systemic Functions"

Sections 5.2.3.1 and 5.2.3.2 provide a summary of the sub-categories which constitute this category.

5.2.3.1 "Administering Change"

"Administering Change" emerged as a sub-category of **"Acknowledging Systemic Functions"** as I had identified that within interviews change was a constant feature that occurred within the teams. Based on this information it may be suggested that change comprised the status quo in modern day health and social care services.

Originally, I had labelled **"Administering Change"** as **"Managing Change"** however renamed this as participants reported that change was imposed on them and that it was their responsibility to administer the process to operationalise what was proposed without being able to influence the original decision. To "manage" suggested that they had an element of control over whether the changes took place, which the participants reported they considered that they did not have, hence the slight change of phrase to "administering" instead.

There were three concepts within **"Administering Change"**:

5.2.3.1a Changing the service

I interpreted this concept to comprise issues relating to how staff undertook the change process, their feelings in relation to this and their concerns for the future. Change, within this study, was perceived by the participants as a stressor, due to the frequency with which it occurred, and their inability to prevent this happening. I recognised that there was therefore recognition that the participants had experienced an ongoing series of alterations and losses to their ways of working that they were expected to operationalise, whilst still maintaining the provision of interventions.

In spite of this situation, participants appreciated their own responsibility in ensuring that services continued to perform whilst **Being told what to do**, as well as having responsibility in **Making change work**.

"It changed because the organisation told us that we had to. We didn't have any choice, it was sort of a done deal that it was going to happen" PT4, transcript line numbers 38-40

"they might have the authority but we all have a responsibility to make the team work better and to make service development work" OT 1, transcript line numbers 237-239

Indicative of this concept was the **Frequency of change** and amount of changes that were reported as taking place. The quote below summarises the extent of this:

"If I am completely honest I have never worked for a service that has changed so much. I will have been here five years this October and the changes that I have seen are crazy" N 5, transcript line numbers 59-61.

Ways of managing the volume of change was suggested to be assisted by communication. The participants highlighted **Interacting with others**, provided them with an opportunity for **Talking through change**. I perceived that this emphasised the strength they received from mutual support from their colleagues to manage the situation and contribute to decision making.

"We would have a discussion with them about why we would want to change things" OT 5, transcript line numbers 272-273

A variety of methods and styles of communication have previously been noted and the importance of team meetings, as a forum for debate, became evident amongst all of the participants. They were described as places where events could be discussed without recrimination; not just those that had taken place successfully, but also situations where things

could have been done better in order to learn from them. That participants considered that they were able to have this dialogue implies a culture of **Trusting each other** and **Respecting each other's view**, **Contributing to team cohesion**.

"We do really gel as a team, we respect each other. The team meetings are an example of how we work together. I think respect has grown as well..." PT 7, transcript line numbers 336-338

Due to the difficulties associated with **"Administering Change"**, participants reported that emotions may run high in some team meetings. For me, this reinforced the earlier documented theme of positive interpersonal relationships as it was reported that colleagues were united in communicating with others to support them on these occasions. Participants presented as **Being genuine** in the extent to which they demonstrated concern for others.

"But I know where there have been situations over the last couple of years, there have been people who may have gotten a bit upset in a team meeting or anything like that and everyone very much rallies around them and you know, checks up on them, and I guess that is not really something that you can manufacture" PT 2, transcript line numbers 265-269.

Whilst the initiation of change was often outside their control, the participants aligned themselves with each other to seek out the information they required. Where uncertainty arose, solutions were sought through the process of **"Facilitating Interaction"** with others.

"I think what makes our team successful is the absolute ability to do joined up working and to be able to say "actually I don't know much about this but I know somebody who does" and it's that information sharing and that ability to rely on your colleagues" N 1, transcript line numbers 131-134

Change had previously not been considered a factor contributing to the development of interprofessional collaboration, however, I would propose that an assumption may be made that it did assist, at least in this study, with enabling integrated working, due to the need of the participants to put coping strategies in place to manage the stressors that emerged during it, uniting colleagues to determine ways of responding to these.

5.2.3.1b Reviewing processes

When service re-design was discussed by the participants there was recognition of the interpersonal and process oriented components of it. Whilst the previous concept had considered interpersonal elements, this concept emerged in response to the practicalities of operationalising new ways of working.

I had originally labelled this concept **Introducing new processes** however I subsequently renamed it **Reviewing processes** to encompass how participants made changes to existing situations as well as introducing new ones, ***Working together*** to do so whilst ***Keeping an open mind***.

"I think people are open to ideas here if they are going to work and make life easier" OT 5, transcript line numbers 157-158

Incidents were reported, by the participants, suggesting that sometimes sufficient time had not been offered to assess if a previous change was working before ***Introducing new ways of working***.

"Plenty of time to adapt but it is forever changing. Before we know something is working there is another idea coming in, and it's a case of can we just not see if this works first" N5, transcript line numbers 67-70

Putting the above situation into context, participants considered this as a stressor that required management as they highlighted that they were

often tasked with the role of operationalising changes that were determined by managers at strategic level.

To cope with these situations participants reported working together to implement the changes in a way agreed between themselves, whilst still meeting the requirements of the commissioners. Through communicating with each other in this way they had developed coping strategies to achieve consensus.

5.2.3.1c Impacting on infrastructure

Upon analysing the data relating to this concept, I considered that the loss, or change of material resources was particularly emotive for participants within those services that were re-designed and where groups were merged together.

Similar to the concept above, in which different ways of working had created adversity, this concept related to the practical tools required by the participants to undertake their operational role, for example location of their office or use of technology.

Stressors caused by the changes to the infrastructure were reported to impact on the psychological health and wellbeing of the participants as well as the real practicality of them being able to undertake their occupational role.

Initially this data was going to be discarded by myself following analysis, however, upon further reflection; it was the recognition of how participants responded to these situations that prompted me to rethink in relation to this.

Responding to these stressors was reported to require "**Facilitating Interaction**" as the participants communicated with each other, working together to develop coping strategies to manage them. In the process of doing so, this consolidated collaborative practices as participants

enhanced allegiances through devising shared solutions to the problems created by their difficult working environments.

Examples of where this occurred was where teams were reported to be merged together in new settings, with participants often **Describing the location of the team** as restrictive and **Lacking resources**.

"it was a really difficult time two years ago because we were literally uplifted out of big offices where we had plenty of space and then just sort of back in here and then suddenly those teams didn't have their desks and then suddenly there was a lack of room" OT 2 transcript line numbers 246-249

The practical impact of this **Merging services** did not just relate to the lack of space in the office but also issues such as increased noise levels, **Describing difficult office environment** and even having to take into consideration the ability to park due to **Lacking parking facilities**.

"I think we all found it difficult with the environment being a lot noisier because your office space is where you sit in and do your work at the computer and there were constantly people in and out and the practical things like the car park space and general space for things and head space" PT 4, transcript line numbers 84-88

An additional stressor placed on participants was the awareness of the potential for working differently, as a move towards **Using technology** to work flexibly could restrict access to an office environment. This led to some **Feeling concerned** and **Fearing for the future** as already identified in **Expressing dissatisfaction in employment**.

"I think we will be encouraged to work from home as soon as we get technology. But SURELY we will have to have a base somewhere to meet up for training and things." PT 1, transcript line numbers 197-200

These practical considerations raised concern in relation to their ability, in terms of, "**Relating To Others**" and **Interacting with others**. Participants identified that this would require them to alter working practices to facilitate this, indicating they recognised the value and worth of these communications by suggesting alternative means to continue these.

"We will certainly come into the office from time to time but not as much so that might be a bit more of a challenge. We might have to have a bit more phone conversations and things like that". PT 2, transcript line numbers 291-294

The stressors highlighted by the participants within **Impacting on infrastructure** indicated, to me, that they were therefore significant enough to create what was perceived as difficult working conditions for the participants affected. However, through maintaining lines of communication by **Interacting with others**, participants realised their feelings were not unique to them, but were also experienced by others and, therefore, appeared willing to try and overcome these difficulties. This contributed to them ***Working in conjunction with others*** in ***Devising coping strategies***, which they perceived as contributing to the development of collaborative practice. I perceived that their willingness to put in place contingency plans to maintain consistency and preserve this way of working as much as possible was a significant finding, as I construed that this reinforced the importance they placed on their integrated practices.

5.2.3.2 "Undertaking Interventions"

My emphasis in the study was on the exploration of participants' experiences of undertaking interprofessional collaboration within the contextual setting of intermediate care services, with participants advised, during interview, not to discuss patient confidential information. The

intent was to focus solely on the perception of the participants during the interviews.

However, the sub-category "***Undertaking Interventions***" was my interpreted response to the operational processes and shared clinical frameworks, which were mentioned during the interviews and the impact that these were reported to have on collaborative practice.

When the criteria for intermediate care services was first published (DH 2001), shared documentation tools were actively encouraged as characteristic of this type of service. Therefore, rather than discarding this emergent data, I instead recognised that the standardisation of clinical practices and processes was meaningful for the participants in creating and sustaining interprofessional collaboration within the services in this study and coded accordingly.

There are two concepts within "***Undertaking Interventions***" as individuals were ***Managing the episode of care*** and in the process ***Learning whilst doing.***

5.2.3.2a Managing the episode of care

Participants reported working very closely with their colleagues to manage the interventions required by their patients. The conceptualisation of this relates to the issues raised by participants in relation to the clinical actions that patients required, whilst appreciating that the participants themselves were facing adversity within their service. This concept describes the functional as well as the relational elements of collaborative clinical processes. I recognised that participants demonstrated a shared commitment to their patients as well as each other.

Reinforcing the extant literature, due to the complexity of patients admitted to their services, participants highlighted that it was not possible to treat them with input from just one profession, instead requiring a variety of professional skills, ***Providing clinical interventions*** dependent upon the needs of the patient.

"Erm, I think because when you are talking about being client centred and providing that care then it is not, you know, one discipline. You need a cocktail of disciplines don't you to provide that care?" OT 4, transcript line numbers 29-31

I perceived this to have implications on how the participants perceived their professional identities suggesting a group rather than profession specific one, through the use of consistent pathways and processes. This complemented the conceptualisation of **"Awareness Of Others"** and contributed to sharing tasks and **Working flexibly** to manage the levels of interaction required.

"we all take responsibility for generic tasks through a key worker system so that when a key worker is identified on admission, that person, regardless of their professional background will take on board generic duties" PT 7, transcript line numbers 72-75

Preparedness, by the participants, to share knowledge, skills and competencies, encouraged a uniformity of approach, which was suggested to enhance the consistency of interventions. By all participants **"Acknowledging Systemic Functions"**, in this respect, this was perceived as fostering greater collaborative working between the different professions and grades of staff within the same team, **Managing complex cases**. The presence of "professional preciousness", in providing these interventions, was suggested to be minimal, instead indicating that the most appropriate person to provide intervention should be anyone with the relevant skills. To work across traditional professional boundaries in this way could be argued to reinforce the acceptance of collaborative practices.

"The way I see it from our managers is whoever has... if the patient is presenting with a problem and you have the skills to deal with that problem then by all means go ahead and deal with the problem" OT 7, transcript line numbers 251-254

Whilst aligning themselves with colleagues from the same service there was, however, concern about **Receiving referrals** from hospital based staff. This was a common theme raised by all of the participants. The process of doing so was described as a potential battle of wills between the referring service and the receiving one. **Facing challenge from others** within the acute trust took place, if a referral from a hospital ward was not accepted.

"Goodness me, we do not say no to anything because if we do, you can guarantee you put the phone down, count to 10 and it will ring again and will be some bigwig in the trust wanting to know why you have said no. So we don't. But we do ensure safety" PT 5, transcript line numbers 207-210

Participants therefore considered that they have no option but to accept all referrals, placing themselves and potentially the patient at risk. They advised that as much as possible they were **Using robust clinical governance** strategies, however in spite of these attempts to prevent admission to their service; participants reported that sometimes patients were admitted against their advice. Whilst this may lead to them **Having no choice**, they recognised the process of **Admitting patients** will still occur anyway, therefore they may as well accept the inevitability of it.

"We might feel uncomfortable but it doesn't make any difference because they still come anyway!" N 2, transcript line numbers 230-231

Comparable to other data, these situations were also perceived as significant stressors. Whilst this had impacted on the interpersonal relationships between participants and those external to the service, interestingly, it had led to them **Working in an integrated way** with their internal group members in order to manage what "outsiders" threw at them. Negative comparisons were therefore made by the participants

between themselves and others that they considered not to be part of their internal group.

Upon reflection this was a feature of successful collaboration that I had not anticipated at the start of the study; the nature of putting up a united front and of protecting each other in the face of adversity. For me, this reinforced the sense of allegiance and kinship articulated by the participants, and the extent to which interprofessional collaboration had become habitual practice for these individuals.

5.2.3.2b Learning whilst doing

In considering the interpersonal relationships between themselves and others, participants reflected on the extent of knowledge demonstrated by their colleagues. This led to further exploration of opportunities and examples where they considered that they had learnt from their colleagues and others with whom they came into contact with, in effect ***Undertaking situated learning.***

"I will tell you who I have learnt SO [emphasis on this word] much from is our MS nurse. 'Cos she thinks completely differently to all the therapists, she thinks left of centre" OT 1, transcript line numbers 158-160

I therefore labelled this concept ***Learning whilst doing*** to reflect the role of situated learning in the workplace. This was constructed as enabling participants to develop their skills, but also to reinforce the parameters of practice expected of them within their roles, through ***Participating in professional socialisation.*** Comparable with other concepts, the situated learning undertaken was continuously under review as changes were introduced to the services, and a re-evaluation of ways of working was requested.

Other codes within this concept included ***Participating in in-house training*** and also ***Undertaking further training*** in order to assist with

setting the parameters for how participants would be expected to practice within their occupational roles.

"working with each other and you just learn as you go along..." N3, transcript line numbers 109-110

Therefore, even though there was a lack of access to formal training opportunities, suggested to be the case due to financial constraints, participants did recognise the opportunities available from learning from their colleagues whilst undertaking the tasks required of them and

Observing others.

"People spend an amount of time when they first come to the job working alongside and shadowing the other professions" PT 7, transcript line numbers 78-79

Through learning from others this was perceived to provide the continuation of the service culture as well as providing order and stability within the teams as participants operated based on a shared understanding and consistency of approach, however realistically this may also be perceived to engender the continuation of undesirable behaviours and standards in some settings.

Similar to Suter et al's findings (2009), during the interviews within this study the junior grade participants reported that, with the support of their colleagues within their service, they had worked through feelings of professional preciousness and had recognised the benefits that sharing competencies offered to collaborative working. One in particular commented on the extent of learning that had taken place since she had left university, ***Describing undergraduate training*** as not fully meeting her needs;

"There is only so much you can learn at university for these kinds of jobs isn't it? It's a bit like learning to drive a car. You learn when you pass don't you?" OT 6, transcript line numbers 156-158

This led me to have further discussion about undergraduate education with participants, the limitations of which were recognised by the junior as well as senior grade staff. Due to this being perceived as quite restrictive, and predominantly uni-professional, there was the acknowledgement that, upon initially joining the services, it could be uncomfortable for some to share their skills and knowledge with others, and take on those of other professions too.

I construed that participants appreciated a need to support and enable their colleagues to enhance their undergraduate learning and coded this as ***Undertaking further training*** and ***Standardising practice***. Within this study I interpreted that informal learning within the workplace was therefore perceived by the participants to be of more value than undergraduate or post graduate formal IPE, suggesting that the former was a more accurate reflection of what was required of the participants in their operational role to enable them to assimilate the expected norms, values, beliefs and behaviours of the culture within which they were situated.

5.3 Summary

Undertaking the processes that are characterised within Constructivist Grounded Theory studies two inter-related categories conceptually emerged from the data:

- ***"Relating To Others"***
- ***"Acknowledging Systemic Functions"***

I conceptualised that the combination of these led to the emergence of ***"Facilitating Interaction"*** as the social process that underpinned interprofessional collaboration within the services participating in this study. Participants recognised the value and significance of working in an integrated way with their colleagues, freely communicating on personal as well as professional levels to assist in maintaining this through the development of shared meanings and understandings. This led to the

achievement of consensus and consistency in approaches through the application of coping strategies.

Whilst the presence of data relating to the interpersonal elements of interprofessional collaboration was anticipated at the outset of the study, what I had not foreseen was the impact that systemic functions also had on encouraging collaboration by encouraging the development of unity to manage the numerous stressors the participants reported facing, which impacted on them both personally and professionally.

The following chapters will discuss these findings in more detail. It will draw on the data and also contemporary literature to do so to locate the study within the context of modern day health and social care services, but also within the arena of ever evolving knowledge in relation to interprofessional collaborative practice.

Chapter 6 – Discussion of the findings

Introduction

The aims of this study were to explore the subjective experiences of participants working in an intermediate care setting, to illuminate the meanings they apply to this reality and to generate a theory identifying the factors that enable interprofessional collaboration to be created and sustained within these settings.

Whereas the previous chapter contained a descriptive report of the data analysis, this chapter will discuss the findings in more detail, to enable greater insight into how the participants perceived the presence of interprofessional collaboration within their services. It will also present the theory that subsequently emerged from the data collection and analytical processes.

This chapter will be split into four sub-chapters to do so:

- a. *Theorising interprofessional collaboration* – this expands on the theoretical overview of interprofessional collaboration that emerged from the data and is developed based on an interpretation of the participants' responses. The theory generated forms the baseline for what was learnt in this study about interprofessional collaboration. The *4Cs of Interprofessional Collaboration*; with the interaction of communication, consensus, coping and consistency, were identified during data analysis and these will be explored further in the following three sub-chapters.
- b. *Communicating to achieve consensus in collaboration* – "***Facilitating Interaction***" emerged as the core category, illustrating the social processes of how the participants actively interacted with each other to negotiate understanding, share meanings and agree expected parameters of practice. This sub-chapter will explore further how this consensus was attained

through the communication that took place between the participants, contributing to the creation of a strong collective identity and allegiances.

- c. *Developing coping strategies to facilitate collaboration* – based on the analysis of the data it became evident from every service and participant that internal and external stressors affected them within their occupational roles. This sub-chapter will consider the impact that the adversity, resulting from these, had on individual and collective behaviours, and, in particular, on the creation of unity and kinship. Emotional resilience and the development of coping strategies were key to enabling participants to manage the situations they faced, and to cope with the stressors present in the modern day NHS.
- d. *Achieving consistency in collaboration* - through managing behaviours and actions in a way that complied with the cultural expectations of their respective groups, individuals were socialised to function flexibly within the accepted parameters of practice for their contextualised setting. *Dynamic Consistency* therefore emerged from the data analysis and the *4Cs of Interprofessional Collaboration*, to conceptualise the social processes that were perceived to be key factors, within this study of sustaining this way of working. Beliefs, norms and behaviours were perpetuated through establishing a collective identity which became a baseline for accepted practice, thereby reinforcing consistency in approaches.

These four sections indicated in the sections above will now be explored in turn as separate sub-chapters, following the theorisation of the findings.

Sub-chapter 6a - Theorising collaboration

Introduction

Robinson and Cottrell (2005) and Reeves (2010) contended that the interprofessional field has been “under-theorized” in the past, with Reeves and Hean (2013), noting that there was, at the time of their writing, some resistance to the use of theory within interprofessional practice and education. They proposed, quite understandably, that a reason for this was that “practitioners did not have the time or inclination to explore theoretical frameworks”.

However, they also counter this by noting that more recently there has been an increase in the use of theory, from different disciplines, both within IPE and the interprofessional arena that has taken place (Reeves and Hean 2013). Their reasoning for this was two-fold, that it was to enhance the field of academic development or to explain the findings from empirical studies.

Within this study, Constructivist Grounded Theory provided the conceptual framework for the formation of theory, by attributing meanings to the participants’ interpretations of their behaviours (Suddaby 2006, Charmaz 2011).

This interpretation, but also the reflexive acknowledgement of the role of the researcher, occurred at the point in time and context that the interviews took place (Horsburgh 2003), during the different stages of analysis, but also continued during the writing up period. The lack of detachment by the researcher during these processes was in contrast with the objective epistemology that guided the original version of Grounded Theory. This was therefore a continued consideration during these stages to ensure data was not forced into preconceived directions, a situation Glaser and Holton (2004) direct researchers to avoid, and which Charmaz (2014, p. 32) calls “vantage points”. In doing so, she reinforces the need

for researchers to “remain as open to what we see and sense in our research”.

This sub-chapter will initially revisit theory generation within the context of Grounded Theory studies before presenting the emergent theory from the findings of this study. It will also consider the presence of the theoretical perspectives of Symbolic Interactionism and the Social Identity Approach within this study.

6a.1 Theory generation in Grounded Theory studies

Silverman (2006) and Polit and Beck (2010) both defined theory as a way to define and/or explain a phenomenon. Theories comprise a scheme of interrelated concepts that offer a logical pattern of explanation and interpretation for what happened in the study area, why individuals act in the way that they do (Gray 2007, Reeves 2010, Birks and Mills 2011, Holton 2011, Reeves and Hean 2013), and a prediction of what is likely to happen in the future (Glaser 1978, Reeves 2010). Theories should therefore not be considered as static entities, but have the potential to be modified as and when new information arises to ensure they continue to be an appropriate understanding of the situation they pertain to.

Glaser and Strauss (1967) proposed that a Grounded Theory must fit the substantive area and those involved in this area must be able to understand it. It must also be sufficiently generalised to allow for its use within many situations within the substantive area and offer at least partial control for the user over these situations, enough to make the theory worth applying to them.

In accordance with the methodology used in this study, Charmaz (2014, p. 231) proposed that “interpretive theories aim to understand meanings and actions and how people construct them”. Understanding is achieved through interpretation of the phenomenon and this offers a greater priority than explanation (Charmaz 2014).

The theory generated from this study is therefore an interpretation of the participants' meanings and actions, and upon reviewing it, participants have concurred its relevance for their contextual settings, signifying that, from it, they have gleaned insight into how they practice. It is also proposed that the theory, documented within this study, may have the potential to be transferable to other settings. In order to enable its potential for use within these, whether this be within or external to health care, the theory has been generated using language that may be considered sufficiently generic to enable it to do so.

6a.2 Developing the theory within this study

The previous chapter has presented the findings from this study with the concepts attained abductively from the data and subsequently merged into the higher order formation of sub-categories and categories visually represented in figure 5.

During data collection, analysis and constant comparison of the data within this study, the foundation of interprofessional collaboration that emerged, was the collective and individual means that participants formed their interpersonal relationships through the social process of interacting with others. As a result, "***Facilitating Interaction***" was considered to be sufficient to be the core category contributing to this. The following section presents the Grounded Theory that emerged from the findings of this study. It is an account of my interpretation of the findings, taking into consideration information provided by the participants about "What people do in specific situations" and "How they do it" (Charmaz 2014, p. 228). Taking the analysis a stage further, questions were also asked of the data as to "why" the participants behaved in the way that they did.

6a.2.1 Constructing the theory

Upon reviewing the developed concepts and categories, the data continued to be analysed to seek further insight into the relationships

between them. Approaches to practice emerged that were repeatedly articulated by the participants, thereby implying their significance within all the services in the study. Participants described the proactive ways that they maintained a stable approach to interaction between the membership of their respective social groups through, wherever possible, working within defined parameters of practice to achieve this.

The participants placed value on supporting each other to manage the stressors they faced, negotiating working practices and processes to maintain consistency in spite of frequent service re-design. Recognising that this statement offered insight into the participants' relationships with each other, a decision was undertaken to split it into four characteristics so that they could be explored further:

- Communication
- Coping strategies
- Consensus
- Consistency

It should be acknowledged that these should not be considered in isolation but are interlinked components which contribute to a greater appreciation of the actions by the participants in this study. I labelled them the *4Cs of Interprofessional Collaboration* as my interpretation of the meanings that were applied by the participants to the social processes they utilised in order to create and sustain interprofessional collaboration with their colleagues. The inter-relationships between these four concepts are presented in the radial diagram below, highlighting the relationship of these to the central concept of interprofessional collaboration. Within sub-chapters 6b-d each of these four components will be explored further within the context of contemporary literature, however a brief summary will be provided here of which concepts and categories contributed to their development as comparative analysis of the data available motivated theory construction.

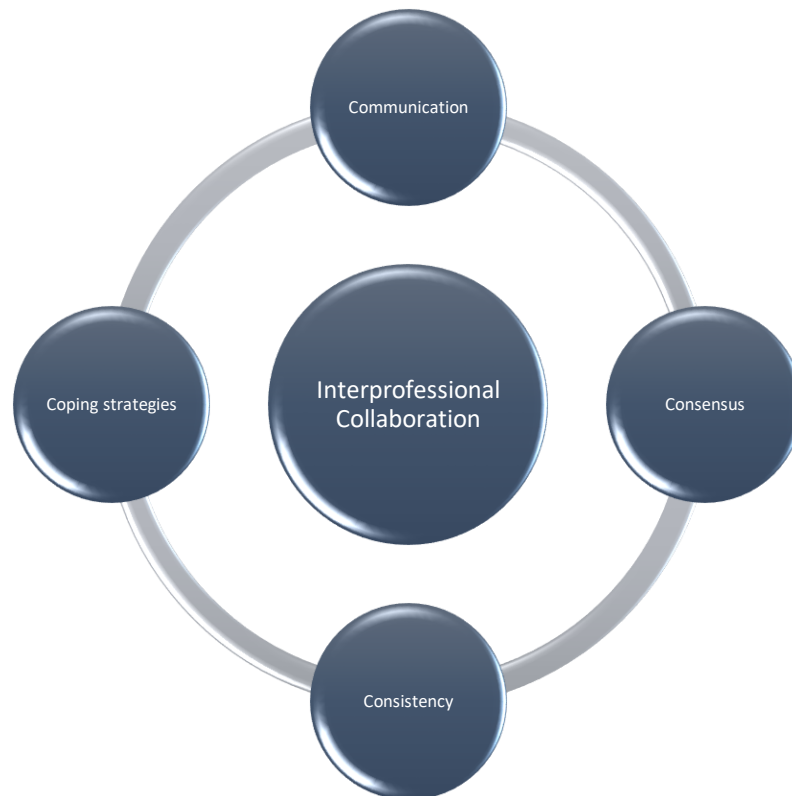


Figure 8 The 4Cs of Interprofessional Collaboration

6a.2.1.1 Communication

From the analysis of the data, **"Facilitating Interaction"** was indicated as the core category and I considered that this reflected the significant amount of, and varied styles of communication that took place between the participants on an explicit or implicit level. Through the data within **"Relating To Others"** this indicated that the participants placed value on strong and positive relationships, describing an **"Awareness Of Others"** to achieve mutual understanding and respect as well as a greater appreciation of colleagues' roles, skills and abilities. Information was sought and shared, across traditional professional boundaries leading to the suggestion of a high sense of kinship and cohesion.

Data within the constructed concepts indicated that participants worked across networks when **Developing Relationships** and actively engaging with others, **Promoting Collaboration** when doing so. The relevance of communication, as a component, was also evident within the category

"Acknowledging Systemic Functions" as the participants responded to changes in service design and the subsequent impact that this had on the infrastructure and other resources

The *4Cs of Interprofessional Collaboration* should not be considered a linear process, but instead interlinked components, with the presence of communication was perceived to be a key component utilised in the development of coping strategies put in place by the participants to manage the stressors they faced in their occupational roles.

6a.2.1.2 Coping strategies

Participants frequently articulated concerns about uncertainties in their role, losses they had faced in terms of infrastructure and personal resources, but also demands that they needed to manage when undertaking their occupational roles. They considered the magnitude of these stressors as significant. This was articulated as **"Experiencing Professional Issues"** whereby participants reported feeling under pressure assisted by **Interacting with others** to seek support to put coping strategies in place.

Within the data the participants attributed these stressors as contributing to them **Expressing dis-satisfaction in employment**. Whilst this was interpreted by myself, initially, as a negative concept, the positive elements of it were later recognised as through **Reinforcing professional practice, Changing the service, Reviewing processes** and **Managing the episode of care**, participants responded to the stressors by putting in place alternative courses of action. I interpreted this as them working in conjunction with each other to achieve consensus and consistency.

6a.2.1.3 Consensus

Due to the flexible nature of the work undertaken and the individualised needs of the patients, this required the participants to work

autonomously, but within negotiated parameters of practice. To enable them to achieve this, the participants had indicated that they had, at times, taken steps to avoid conflict and to make compromises during the process of **Interacting with others**. I interpreted this to mean that they had put deliberate strategies in place to decrease the possibility of negative behaviours or potential conflict, **Reviewing processes** and **Reflecting on practice** when doing so.

The actions taken to achieve this were indicative of those already noted above in section 6a.2.1.1 which described my interpretation of how the participants communicated with others. Whilst this reflected, what I perceived to be, the social processes that the participants took, I interpreted that the outcome they achieved, or hoped to achieve, from this was the maintenance of order and stability through negotiating to attain consensus. This also provided them with opportunities to learn from those with whom they came into contact with, in effect, **Learning whilst doing**. This contributed to the development of consistent practices and processes, setting out negotiated parameters of practice for the participants within each service.

6a.2.1.4 Consistency

As noted in the sections above, participants proactively undertook formal or informal interactions, adopting strategies to ensure that their experience of working with their colleagues, as well as the patients, was as unchallenging as possible due to the extent of other stressors they faced. From the data available, I perceived that the implicit expectation, from the participants, was that others would also behave in the same way to achieve a positive outcome for the interaction and maintain consistency of approaches.

These took place at personal and professional levels and I considered consistency to be of particular relevance when participants reported **Undertaking Interventions**. This was due to the extent of shared

competencies that required participants to take on tasks that, in other services, may be perceived to be specific to other professions. In undertaking activities and processes in ways that were agreed between them, I interpreted this as **Reinforcing professional practice**, working in a way that may be unique to their service, but also to agreed professional standards within the requirements of their professional regulatory bodies.

Participants articulated that this required them to be **Reflecting on practice, Reviewing processes** and, in doing so, led to them **Learning whilst doing**.

6a.2.2 The construction of *Dynamic Consistency*

Taking the analysis a stage further and following further abstraction of the data, consideration was given to the outcome that would be achieved by the participants through the social processes that took place when combining ***"Facilitating Interaction"*** and the 4Cs of Interprofessional Collaboration. I conceptualized this as **Dynamic Consistency** to reflect that the participants articulated proactive ways of carrying out actions according to the demands of the situation, working flexibly and adaptively within negotiated parameters of practice to ensure consistency of approaches. This related to the behaviours, attitudes, norms and values they exhibited as well as to agreed practices and processes.

Participants highlighted that within these negotiated parameters they worked autonomously. Due to an increased awareness of others and the interpersonal relationships, generated as a result, they were able to anticipate the actions and behaviours of their colleagues and respond accordingly. This often took place without the need for explicit communications and sometimes required them to adjust their own behaviour in doing so. This conceptualisation was therefore particularly relevant to the data documented in the categories ***"Relating To Others"*** and ***"Acknowledging Systemic Functions"***, due to the frequency of

change and the stressors indicated by the participants that these created for them. I began to appreciate that when changes occurred, the participants re-evaluated their situations and negotiated these with others to recreate a state of *Dynamic Consistency*. Upon considering the maintenance of this state of stability at inter-personal, collective and systemic levels, this was constructed as providing the perspective for how collaboration was organised and understood by the participants within this study.

Therefore, in spite of a utopian perspective of interprofessional collaboration within the legislative framework of the NHS, stressors and adversity were indicated to be the norm within the services participating in this study. Significantly, these stressors impacted on participants' wellbeing. However, based on the responses from the participants, they also encouraged the development of interprofessional collaboration as the participants united to put coping strategies in place to manage them, sharing their common experiences to negotiate and establish routines and parameters of practice to contribute to attaining consistency.

Akin to the Social Categorization approach, it is therefore argued, theoretically, that interprofessional collaboration, within the context of the services in this study, is a socially constructed concept that is based on the participants' interpretation of their relationship with, but also their comparison of, others (Hornsey 2008). This includes those individuals who were positioned internally, as well as externally, to their social group. Reinforcing Gittel and Weiss (2004) perspective, a significant amount of the information exchanged between individuals was transmitted on an informal as well as a formal basis. The generation of mutual knowledge and understanding, through this, was a contributory factor to overcoming traditional professional boundaries as participants reported a sense of security to be able to speak openly and freely.

6a.2.3 The Grounded Theory

Returning to the development of the Grounded Theory within this study, Glaser and Strauss (1967) suggest that rather than generating a theory that explains everything in that area, the emphasis of Grounded Theory is to provide an overview, and a new perspective of the situation under study. In doing so Hean (2014) suggests that theories must be clear and concise with a minimal number of concepts, and have the potential to be used in practice (Hean 2014).

The emergent theory follows the lead of these authors. Within the context of this study, it was determined that the presence of the internal and external stressors offered a different perspective in relation to the creation of interprofessional collaboration. It was abstracted that the responses, by the participants to these stressors, led to the emergence of kinship and cohesion.

The following statement encapsulates the Grounded Theory which I perceive to reflect the practices and processes located within this study and has the potential to be utilised in a variety of different settings:

*The participants interacted, within their contextualised settings, **communicating** with each other to achieve **consensus**, as much as possible and applying **coping** strategies to manage the internal and external stressors affecting them.*

*By working proactively in this way, **consistency** of meaning, behaviour and culture was attained, offering a sense of stability and order within settings that were frequently affected by change. In doing so, these social processes contributed to creating and sustaining interprofessional collaboration.*

To offer a summary of how the theory was developed, the interactions reported by the participants contributed to the development of the core category "**Facilitating Interaction**", and the categories of "**Relating To**

Others” and ***Acknowledging Systemic Functions***”. These represented elements of the explored phenomenon of interprofessional collaboration, based on the co-constructed analysis of the contextual exchanges, between the participants and myself.

The inferences from these co-constructions were that, through engaging in interprofessional interactions, participants managed their behaviours and responses, in a habitual way that complied with the cultural expectations of their in-group, making sense of exchanges to achieve consensus and ensure the maintenance of consistency, for their perception of reality of the service, even when faced with significant adversity and challenge. The categories emerging from this data led to the theoretical conceptualisation of the *4Cs of Interprofessional Collaboration*.

Following interpretation of the strategies used by the participants to facilitate interaction, a *Dynamic Consistency* of approach between colleagues was perceived to be a key factor in sustaining interprofessional collaboration. This term was applied to characterize situations where individuals function flexibly and autonomously, but within the defined parameters for holistic participation at interpersonal, operational and strategic levels of interaction as members of social groups. This finding is in line with Allport’s (1954, p. 40) concept of “approximate conformity”, whereby people may deviate from the norm only as long as it is within a “range of tolerable behaviour”.

The point at which *Dynamic Consistency* was fully assimilated by participants varied depending on the stage at which they were on their journey to full membership within the wider service. Based on their responses there was evidence that some participants appeared to cope with personal, professional and organisational stressors which hindered this, better than others. Whilst this was determined to impact on

participants' psychological and professional wellbeing, there was evidence of intragroup support to assist with this.

In addition, it was determined that the development of individualised, and collective, coping strategies contributed to enabling these hurdles to be overcome. Significantly these also directed the promotion of consistency and stability of practices and processes within the wider collective, ultimately leading to the achievement of a sense of order.

The theory developed as a result of this analysis may therefore be used at an operational level to highlight to staff, from any service that it is possible to break down professional barriers and create a collective identity stronger than that of individual professional ones. It may also be used educationally, to encourage students to recognise the value of working collaboratively with their colleagues to develop relations and alliances, for the benefit of their service but also their own individual wellbeing. This would offer them increased insight into the expectations in relation to collaborative practice, which are required of them upon qualifying, a situation the band 5 participants in this study suggested that they were not fully aware of.

6a.3 Identifying links to Blumer's premises

As previously reported and, linked with the origins of Grounded Theory, the theoretical perspective underlying this methodology is that of Symbolic Interactionism, with its emphasis on the construction of meaning and ultimately order within the social groups under study. Within this perspective it is considered that participants learn to view the world based on their interpretation of their interactions with others, through which they develop shared meanings (Sheehan et al 2007, Handberg et al 2015).

During the writing up of this study, and a further review of the literature, similarities resonated between the *4Cs of Interprofessional Collaboration* and Blumer's three premises (Blumer 1969), within Symbolic

Interactionism. This encouraged the opportunity to review and compare these premises with the findings obtained and the theory generated, from the context of collaborative practice in intermediate care settings.

To offer clarity of meaning, the three premises are reproduced below with the comparable *4Cs of Interprofessional Collaboration* from this study's Grounded Theory, positioned in italics, within brackets, alongside the premise that was perceived to offer the greatest similarity:

1. "human beings act towards things on the basis of the meanings that things have for them." (*By working proactively in this way, **consistency** of meaning, behaviour and culture was attained*)
2. "the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows." (*The participants interacted, within their contextualised settings of intermediate care services, **communicating** with each other to achieve **consensus**, as much as possible*)
3. "these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters." (*applying **coping** strategies to manage the internal and external stressors affecting them*)

The applicability of Blumer's premises to the Grounded Theory produced from the findings of this study reinforced the continued relevance of these premises for contemporary situations.

To offer further insight into how this was determined, as epitomised by premise one, individuals faced significant internal and external stressors, hence they strove to create understanding and a consistency of approach and stability, wherever possible, to manage these. This was achieved through the process of communication with each other (premise two), with minimal reports of disharmony or conflict occurring. Consensus was

a recurring theme intrinsic to this as participants responded in accordance with the negotiated meanings.

Premise three is indicative of the situations faced by the participants whereby such negotiations occur constantly. During the process of interpreting interactions, it was noted, in the findings, that participants had to rely, sometimes, on putting coping strategies in place to manage these. Responses were modified based on participants' interpretations of their situations.

Handberg et al (2015, p. 1025), in their examination of Symbolic Interactionism summarised the preservation of order succinctly as "There is freedom of choice in human behaviour, however, this choice is in some way being defined by society and cultural norms". This statement is supported by the findings of this study, in that it is concluded that individual practitioners do indeed enjoy a degree of autonomy in constructing meaning, however to ensure inclusion within their service, expectations are prevalent that their behaviours and actions will be those considered acceptable within the parameters of practice negotiated for it.

6a.4 Social Identity Approach

Taking into consideration earlier comments in this sub-chapter, about under theorisation within the interprofessional field, a theoretical framework was sought that could be considered pertinent to and reflective of the findings of this study.

The Social Identity Theory (SIT) was developed in the 1970s by Tajfel, in conjunction with Turner (Hogg and Williams 2000), to offer an explanation for group behaviour and inter-group relations (Hornsey 2008). This suggested that a person's sense of identity and self-concept was based on their membership and acceptance into social groups, which varied dependent upon the contextual situation (Hornsey 2008, Khalili et al 2013) and was therefore socially constructed.

Within this approach in-group membership of a social group was considered to provide a sense of belonging, leading to an appreciation of positive aspects of the membership and maximising the commonalities of its members. It was suggested by Hogg and Williams (2000, p. 81) to be a “theory of the collective self”.

Through the process of categorisation and social comparison (Hogg and Williams 2000), SIT suggests that group members identify with each other, but compare and contrast themselves with other groups to highlight similarities and differences between them. With this in mind, group members were therefore perceived to view the group to which they belong as different to those external to it and, usually in a more positive light, than the outgroups (Hornsey 2008, Khalili et al 2013). Significantly this could potentially lead to the development of prejudice between them and the formation of stereotypes.

There was evidence of this within the findings from this study which indicated clear differentiations between the participants and ward based staff, but also between the participants and those in managerial and strategic positions too. From the participant’s responses, there was a sense of disharmony between themselves and these other groups which led to the presence of stressors that affected in-group members. The coping strategies and forms of communication that the participants had put in place to manage these stressors, were determined to be an unexpected contributory factor to encouraging interprofessional collaboration through enhancing allegiances between members of the same social group.

In contrast to their feelings about the out-group members noted above, positively, the participants considered their peers within the service as in-group members, irrespective of their profession. This indicated permeable boundaries between the different professions and was an indicator of the extent to which integrated practice and cohesion had developed between the participants and their colleagues. This led to the creation of more than

one identity (Khalili et al 2013) as the participants reported individual, professional, as well as collective identities.

Following Tajfel's death, Turner expanded the Self Categorization Theory (SCT) element of SIT further. However, it has been argued that due to the similarities between SIT and SCT, it is possible to construe the latter, not as an independent theory, but juxta-positioned with the former to contribute to the development of the Social Identity approach (Hornsey 2008). The combination of the two allows for a more holistic exploration of group and interpersonal relationships.

This has relevance for the findings of the Team Circles exercise. Following the collation of these results, but also based on the comments of the participants, there is recognition that individuals within this study belonged to a multitude of social groups. Through the process of categorisation and acceptance, as an in-group member, there is recognition that individuals match their behaviour to, and adopt the identity of that group if they are to be accepted as a full member. Stets and Burke (2000, p. 225) clarified self-categorisation as "an accentuation of the perceived similarities between the self and other in-group members", therefore rather than the suggestion that each participant has a single identity it is therefore proposed that they have multiple social identities, with each coming to the fore depending upon the context of the situation.

The significance of this, within this study, is that participants were therefore not considered in isolation, but within the different contexts within which they interacted and negotiated with others, in particular those with whom they considered to have similar social identification (Stets and Burke 2000) within that contextual setting.

It is through the process of categorisation that individuals with particular commonalities attain a collective identity and are grouped together. Hornsey (2008), observed that the attributes comprising these

commonalities may be termed “prototypes” which define the norms, attitudes and behaviours for each social group. This was comparable to a concept that emerged within this study and which was identified as “working within the parameters of practice” to encompass accepted ways of working for each setting.

Within this theoretical approach these expected behaviours and practices are internalised by the participants through the process of depersonalisation (Stets and Burke 2000, Hornsey 2008) whereby individuals perceive themselves as an embodiment, acting in accordance with the norms, values and expectations of the social group. This is akin to socialisation and underpins group cohesion and uniformity, ensuring the consistency of approaches between the participants. Stets and Burke (2000) suggests that in order to identify as a member of a social group it therefore requires an individual to identify with a category and the behaviours that are perceived to be associated with that category. This may therefore indicate that the self not only exists within society, but is influenced by it as individuals adopt socially accepted meanings into their own prototypes.

This approach also resonates with elements of Symbolic Interactionism, with an emphasis placed on making sense of meanings formed through interactions with others, interpreting these and responding in the manner expected within the social context (Blumer 1969, Bryman 2012). This reinforced the relevance of it as an appropriate fit for the findings of ***“Facilitating Interaction”*** and *Dynamic Consistency*.

6a.5 Summary

This sub-chapter has presented the Grounded Theory generated from the findings within this study and the social processes that emerged from these.

Through the positioning of the *4Cs of Interprofessional Collaboration* within Blumer’s premises, this has also reinforced their role in

contributing to the development of interprofessional and interpersonal relationships. They provide guidance for how practitioners, within this study, developed their relationships to work in a more cohesive way and manage the adversity faced by the participants in their operational roles.

The following sections will take each of the four component parts in turn, discussing how they contribute to the emergence of the core category, and ultimately the creation and sustainability of interprofessional collaboration.

Sub-chapter 6b - Communicating to achieve consensus

Introduction

The previous sub-chapter has presented the theoretical findings from this study and these will be explored further in the forthcoming sub-chapters, commencing in this one with how consensus was achieved through the process of the participants communicating with each other.

Humans are inherently social beings, undertaking interactions with others to create and interpret meaning, as noted in Blumer's (1969) second premise, and the emergent Grounded Theory from this study. Based upon his premises, Blumer (1969) highlighted that social interaction forms, rather than expresses, human conduct with individuals responding in a subjective way to stimuli, dependent upon how they have attributed meaning to them (Charmaz 2014).

Through the process of depersonalisation, highlighted within the Social Identity Approach, participants within this study, internalised the norms, values and beliefs for their group, creating prototypes for behaviour that those within that setting were expected to abide by. This contributed to the achievement of consensus within defined and accepted parameters; creating a state of *Dynamic Consistency* between individuals.

Whilst Martin-Rodriguez et al (2005, p. 144) identified that "collaboration is essentially an interpersonal process", it was identified in the preliminary literature review there has been a lack of evidence in the extant literature of the impact of these processes on collaborative practices or the development of interprofessional relationships.

A later literature review by Hewitt, Sims and Harris (2015) documented, what they considered, was persuasive evidence to support the presence of effective communication in interprofessional practice. This is also supported by the findings from this study which suggest that participants utilised "***Facilitating Interaction***" as a course of action by which they attributed meaning to their situation, clarifying roles, practices and

processes, preserving order and stability in their services, working through challenges, and coping with internal and external stressors during the social process of creating and sustaining interprofessional collaboration.

The following section will explore the social processes used by the participants to create this shared, but subjective, reality that is unique to their own situation.

6b.1 Social processes

The aim of this study, in accordance with the expectations of Grounded Theory, was to explore subjective experiences of the participants and to analyse the social processes contributing to these (Charmaz 2014). The explanations of the social processes undertaken by the participants led to the emergence of recurring themes during the interviews and were a significant source of information to analyse, with which to construct findings.

To clarify understanding of this concept, social processes may be defined as:

“the ways in which individuals and groups interact, adjust and readjust and establish relationships and patterns of behaviour which are again modified through social interactions”.

<http://www.yourarticlelibrary.com/sociology/social-processes-the-meaning-types-characteristics-of-social-processes/8545/>

Accessed 24/11/16

Individual’s lives are socially constructed through continuous and meaningful interaction with others (Goulding 1999), with social processes shaping the “participants actions and understandings within the setting” (Charmaz 2014, p. 34). As participants of social groups, individuals are both shaped by, but in turn, shape the group norms, behaviours and attitudes in conjunction with others. In support of this and within the

context of the services within this study, the findings indicated that social processes were constructed to be undertaken with the implicit aim of the participant, apparently, to maintain consistency and consensus between themselves and their colleagues as indicated within the *4Cs of Interprofessional Collaboration*.

Intriguingly these processes had become so habitual that many participants did not initially recognise that they were working in this way. This may be construed as a similar concept to that noted by Allport (1954, p. 29) of familiarity of existence, whereby what we perceive to be familiar “provides the basis of our existence”. The study within this thesis builds upon this concept explaining it as representative of situations where individuals function within accepted parameters of practice, thereby reinforcing consistency, or familiarity of approaches.

Allport proposed that familiarity adds value to the affiliations that individuals develop with others, suggesting that commonalities emerge between in-group members so that they “all use the term *we* with the same essential significance”. The conclusion from this was that this alludes to a sense of cohesion between them (Allport, 1954, p. 31). This is comparable with the findings of this study as the pronoun “*we*” was frequently used by the participants. However, the context of its use was variable, as it related to the different groups that the participants were members of; whether they be professional or social. The commonality of each time it was used though, suggested the presence of intra-group allegiances within the membership of the different groups. This also concurs with a more recent study than Allport (1954), Banks et al (2016) who indicated that those, with whom we associate more, are more likely to become a collective “*we*” than others with whom the interaction is less frequent.

The concept of allegiances was reiterated within the findings of a study by Suter et al (2009) which also emphasised the importance of cohesion and

unity. They indicated the value of communication in achieving this. Suter et al's emphasis on the wide range of communication strategies to attain consensus, understanding, trust and respect of others is also comparable with the findings of the study within this thesis whereby these were achieved through the process of, what was labelled as, "**Facilitating Interaction**".

6b.1.2 Relational coordination

The strong emphasis on communication within the findings of this study may be compared with Gittell's concept of relational coordination. In contrast to the emphasis, within my study, of exploring the participant's experiences of interpersonal interactions and how they undertake these, Gittell (2012) offers a different perspective, determining whether individuals undertake particular actions within work processes. Similar to the requirements of the Integration Agenda, her intent is to consider the impact of relationships on performance outcomes to ensure efficiency and quality of performance.

Rather than exploring personal relationships, which she does recognise as having the potential to offer a different direction for relational coordination (Gittell 2012), she instead suggests that in situations of high relational coordination it is the shared goals, shared knowledge and mutual respect that connects people irrespective of their personal relationship with others.

Her focus is therefore role and task based (Bond and Gittell 2010, p120), considering communications between individuals to facilitate the coordination of interdependent work and improve performance "under conditions of uncertainty and time constraints", without the emotive effects that interpersonal relationship dynamics can have on these interactions, the importance of which resonated so strongly in the findings from my study.

In spite of this, the findings of both my study and the work of Gittell do bear some similarities. The following diagram in figure 9 is frequently produced in published work by Gittell and summarises, what she considers to be, the key relationship dimensions of high relational coordination. The findings from my study would indicate that these are outcomes of interaction that the participants would concur with, taking the route of the social processes *4Cs of Interprofessional Collaboration* to achieve these.

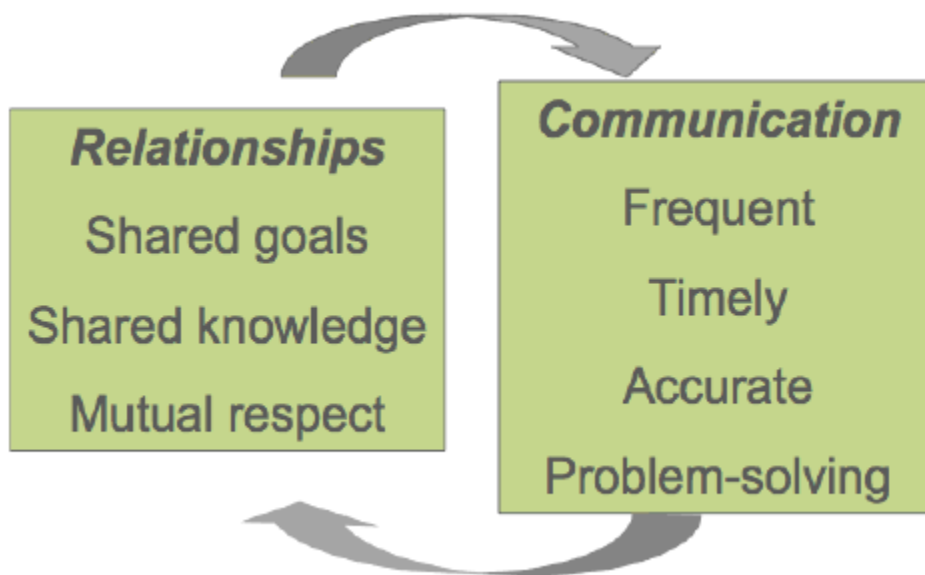


Figure 9 Relational coordination (Gittell, Godfrey and Thistlethwaite 2013, p. 211)

Therefore, rather than using a validated measurement tool, in the form of a survey, to reach this conclusion, qualitative data was used instead, within my study, to obtain rich data to more fully explore the relationship dynamics between the participants and conclude a high level of relational coordination between them. It was not the intent of this study, unlike Gittell's approach, to measure performance, however, it may be considered that by the participants communicating in problem solving, rather than blaming ways that encourage consensus and consistency towards achieving shared goals, knowledge and understanding, putting coping strategies in place to do so, and demonstrating mutual respect,

the participants were functioning at a level of quality of care supported within the approach of relational coordination.

6b.2 Interacting with others - revisited

As noted earlier, Suter et al (2009) also identified communication as a core competency for collaboration. This has been supported within the findings of other empirical studies, which have concluded that the process of interacting with others can lead to the development of open lines of communication, effective interpersonal relations (King and Ross 2004) and the opportunity to share competencies and increase awareness of individual's own and other's skills, abilities and roles (Mickan and Rodger 2005, Suter et al 2009).

Within this study, through the process of "**Facilitating Interaction**" with others, participants constructed their own versions of reality according to the meanings that each applied to the context they were facing. They used the existing parameters of practice as a baseline for applying interpretations with these providing a guide for what may be perceived as an appropriate fit for their social situation. The subjective perceptions of reality that were generated from these interpretations reinforced the value of using a Constructivist approach to explore them further.

Contrary to what may be perceived, upon perusing the changes within the NHS legislative framework at the end of the twentieth century, the relevance of interaction in promoting collaboration is not a new concept. Through his 'contact hypothesis' Allport (1954), is recognised as suggesting that contact between individuals can contribute to the reduction of hostility and prejudice between groups due to the creation of interpersonal relationships and inter-group relations leading to extensive cohesion. He proposed that circles of loyalty may increase in size (Allport 1954), as relationships develop between groups. This is pertinent for the study within this thesis as the findings suggested that the initial intraprofessional relationships have been supplemented by

interprofessional ones with participants interacting across traditional professional boundaries.

To put it another way, as relationships between the participants developed and boundaries between them became more permeable, interpersonal relationships became more salient (Brown, Vivian and Hewstone 1999), thereby supporting Allport's hypothesis. Familiarity of relationships was also recognised by Gittell (2012) to develop through frequent interactions and relationship ties.

Participants demonstrated that they had developed professionally mature relationships once they had overcome the initial episodes of professional preciousness, and had also negotiated and assimilated integrated working practices to enable cohesion. Whilst it was the remit of this study to investigate experiences, rather than quantifiable measurements of service performance indicators, Gittell (2012) has noted that relational coordination that occurs through high quality communications, shared goals, knowledge and respect appears to have a positive impact on achieving quality and efficiency of performance as required by the Integration Agenda.

In spite of this, whilst collaborative practice was an expectation advocated within the legislative framework for the NHS, (Centre for Workforce Intelligence 2013), there was limited evidence, in this study, of the commissioners and strategic managers proactively contributing to the development of this. Instead, participants united to devise coping strategies to manage their situation by utilising interpersonal interactions to develop group processes and responses. In doing so, they introduced inclusive language, shared information and common understandings as advocated in findings by Webster (2002), Sheehan et al (2007), Bihari Axelsson and Axelsson (2009), and thereby created a prototype for behaviour.

These findings support that of King and Ross (2004) who highlight that there are advantages to providing people with space to reconstruct their identities in response to change and was reinforced by Handberg et al's (2015, p. 1028) observation that "Social interaction between people is a process that forms and sculpts human behaviour".

Furthermore, it may also be argued that it is as part of this participation with each other that individuals develop their identity (Handley et al 2006) irrespective of the presence of change. Individuals identify one's own self in relation to others within their social in-group to compare themselves with those external to this (Hean and Dickinson 2005).

Through this process of individuals "constructing meaning within co-constructed social experience" (Handberg 2015, p. 1025), it may be suggested that the social identity of the participants were altered. Due to a change in categorisation and as the intragroup increased its membership, this enhanced the collective, as well as individual, identity.

However, it is appreciated that it is not possible for this to take place without the willingness of participants to embrace collaboration (Suter et al 2009). Reinforcing this perspective within the context of this study, this may be perceived as a contributory factor to the creation of interprofessional collaboration as participants indicated that they proactively engaged and interacted with each other. The findings from my study indicate that participants shared information on an informal or formal basis, which also reinforced Gittel and Logan's recognition that due to increased interdependencies, coordination "has become a less mechanical and more relational process" (2015, p. 3). They did also though, suggest that professional boundaries were reinforced by the presence of specialized knowledge and status differentials, however, there was no evidence of this within the findings of my study.

Suter's perspective was also later maintained by The Centre for Workforce Intelligence (2013) who acknowledged that even if policies and processes

are put in place to encourage the development of interprofessional collaboration there is no guarantee that these will lead to the development of integrated practices, or indeed an improvement in service delivery, an expectation of many historical government policies.

Indeed, King and Ross (2004) indicate that ambiguity in this respect may have the converse effect of reinforcing traditional identities. However, championing the interaction between individuals, McCallin and Bamford (2007) identified that a contributory factor to effective collaboration is the recognition of the diversity of skills and expertise that are required to provide a service for those with complex health needs. They proposed that communication between individuals enhanced disciplinary alliances and encouraged emotional security (McCallin and Bamford 2007).

The extent of diversity within the services in the study in this thesis, following the results of the Team Circles exercise, reinforces the findings of McCallin and Bamford. Participants reported a variety of professions, social groups and organisations that they interacted with on a regular basis, depending on the needs of the client, or the situation within which they were participating. Whilst Gittel (2012) indicates that the presence of disrespect between those who perform different roles is a factor causing divisions within occupational settings, with the intragroup settings within this study, this did not appear to be the case.

Instead, through the process of interacting with others to collaborate successfully the findings concur not only with those of McCallin and Bamford, but also Hall's (2005, p. 194) optimistic comments that "although the barriers traditionally built between the professionals are high, they certainly are not insurmountable".

6b.2.1 Promoting collaboration through team meetings

Open lines of communication were therefore identified within this study as a key factor of effective interprofessional collaboration. Social group

members reported that they had the opportunity to freely voice their opinions and share information with others informally, but also in official settings too. This reinforces a recommendation by King and Ross (2004) of the value of informal as well as formal interaction to increase individual's understanding of others, but also concurs with a perspective of Gittell and Logan (2015) that timely and problem solving communication can contribute to the development of innovative ideas.

The nature of these communications were considered by Hutchings, Hall and Loveday (2004, p. 134) to be at the "heart of collaboration" as individuals interacted with others, both internal and external to their social groups. The different dimensions of communicating with others is considered as a means of measuring relational coordination along with shared knowledge, shared understandings, shared goals as well as mutual respect (Gittell, 2012), her suggestion being that this would enable organisations to achieve better outcomes.

Whilst it has already been noted that the achievement of performance indicators was not a factor explored within my study, participants reported that they attended meetings where there was an opportunity for "**Facilitating Interaction**" with their colleagues to contribute to operationalising service development. For the purposes of clarification, within this section, team meetings are considered to be formal meetings that encompass staff employed within a commissioned service, recognising that participants attending them may comprise membership of a number of social groups, each of which may have their own separate governance arrangements.

Rutherford and McArthur (2004) were cited in the literature review, undertaken by Xyrichis and Lowton (2008), as reporting that these meetings could ensure the effectiveness of services by assisting the breakdown of barriers and to improve communication between the different professions. West and Markiewicz (2004) were also referenced in the same literature review (Xyrichis and Lowton, 2008) and cited as

suggesting that to meet in this way encouraged debate, diversity and differences. Whilst Gittell and Logan (2015) highlight the need for organisational structures to enable participants to understand and work through their differences, the participants in my study reported that there was a lack of support strategically from the organisation to do so. Instead, it was noted that it was the operational managers and the participants themselves who worked collectively to proactively respond to the organisational and work place stressors they faced.

Through the opportunities for interaction this created and the sharing of opinions and negotiation of meanings, it may be proposed that the development of a collective identity was encouraged. Team meetings were also reported as being instrumental in resolving conflict and promoting interpersonal relationships (Xyrichis and Lowton 2008) through encouraging participants to feel valued and reinforcing allegiance to the service and to their colleagues. This reinforced Banks et al's (2016) perspective that whilst traditionally coordination was assumed to occur through top-down approaches, there is a need to recognise how it may emerge through the interactions between colleagues.

An additional finding, of my study, was a perception of these meetings as places for situated learning to occur. This supports a previous study by Nisbet, Dunn and Lincoln (2015). Their findings highlighted that professional diversity within these settings can add to the collective knowledge and may be considered to enhance participant's individual personal and professional cognitive maps.

From the findings of the study in this thesis it was suggested that within the meetings they attended, participants had the opportunity to actively participate in discussion, offering their opinions, and to challenge others appropriately but without fear of reproach, in order to reach a resolution (Hewitt, Sims and Harris 2015, Nisbet, Dunn and Lincoln 2015). However, both sets of authors recommended guidelines for participation and

protocols for resolving conflict within the meetings. Whilst this may be an ideal, they were not evident within the services in this study. Instead participants reported that, due to the strength of the intragroup relationships, team meetings did contribute to managing any disharmony by allowing for the exchange of ideas and to gain insight into other's professional practices (Beunza 2013). This had become the cultural norm, as had seeking consensus in decision making. The latter was also considered by Billups (2001) to be a key factor in interprofessional team processes to encourage full participation by group members.

Through the process of "**Facilitating Interaction**" within these meetings, decisions were considered to be made jointly through negotiation of consensus, a concept also supported by Suter et al (2009). They confirmed that ownership of the decision was therefore reported to be accepted more readily by the group members if trusting and respectful relationships are present (Suter et al 2009).

This is significant, within this study, as where participants highlighted that they had not initially agreed with operational decisions that had been made in these situations, they did recognise that, as they had an opportunity to contribute an opinion and listen to others, they reported eventually accepting the consensus decision.

6b.2.2 Negotiating positions

The philosophical perspective of Symbolic Interactionism views society as a series of ongoing interactions between individuals within a social context, guided through shared understandings and meanings to create order and make sense of events (Weick 2001, Miliken et al 2012).

Through the process of our interactions we attribute meaning to events, differentiating them from others and linking them with events from our past experiences to compartmentalise these (Hills and Gibson 2007), categorise and make sense of them.

Inter and intra-group interactions help to shape the relationships between members of the same social group, but also with those with whom they network outside of them, to develop shared meanings and interpretations (Sheehan 2007). This diversity requires recognition and an appreciation that other's frames of reference are often different, with different professions having their own "cognitive maps" (Hall 2005), developed as part of their professional socialisation.

Within the study in this thesis, these cognitive maps were considered to be enhanced through the process of accepting the prototype of the respective social groups which sometimes required the participant to work outside of their traditional professional remit, thereby increasing the permeability of traditional boundaries within the services in this study.

Webber (2016) noted that, similar to an iceberg, there is a vast amount of tacit knowledge that occurs implicitly and this is shared during the process of interacting with others. A literature review by Hewitt, Sims and Harris (2015) challenged this, suggesting that when norms were implicit they were difficult to be recognised and therefore group members may inadvertently not work to them.

However, when norms were explicit, engagement and negotiation of meaning, through the exchange of information, becomes taken for granted and positioned in individual's sub conscious as practices that are "common sense" (Wenger 2008). Banks et al (2016, p. 1062) reinforced that when such relational routines are in situ they considered that this can decrease the amount of "facilitated interpersonal interaction required" between colleagues. Although Hewitt, Sims and Harris (2015) noted little convincing evidence of the role of norms to enable interprofessional collaboration, the presence of these within this study are argued to reinforce expectations of how members should perform, or behave, within their social groups, but also assisted in emphasising the group's identity.

The group identity, noted within a Social Identity approach was construed as offering a support system, with which to try out new ideas, share information and provide mutual encouragement, within a relatively safe environment (Webber 2016). The presence and the security of such a support system was particularly relevant in view of the physical and psychological difficulties facing the participants in the study within this thesis.

The concept of safety within the working situation is documented in empirical research in Sweden by Sandberg (2010). Similar to the unity demonstrated by the participants in Sandberg's study, this highlighted that the development of "functional synergy" between the participants in the study in this thesis has been claimed to improve the wellbeing of those involved in the interactions.

The proposition by Sandberg was that participation in interpersonal interactions between group members can release physical energies improving an individual's health and wellbeing, a concept that he termed "collaborative health" (2010). However, whereas Sandberg (2010) argues that stressors impair "collaborative health", the findings from the study in this thesis contradict this. Instead, it is noted that whilst negative stressors do indeed impair individual's health and wellbeing for a period of time, the strength of the interpersonal dynamics between the participants in this study generated a collective response to adversity, reinforcing cohesion and unity within the group.

The strength of being part of such a social network is also noted within the concept of "social capital". This was offered by Hean (2014) to describe the health advantages of participating in collaborative working, with an adverse impact being exclusion from this. Inclusion within a network enabled knowledge transfer between participants and may be considered comparable with the in/out group scenario in the Social Identity approach. A prime example of where exclusion occurs, within this

study, is indicative of the negative perception, placed by the participants on strategic managers and commissioners who they considered not to be a part of their networks. This had a subsequent effect of creating boundaries between the operational and strategic staff.

Whilst the concepts of social capital and collaborative health may be perceived as positive perspectives within the field of interprofessional collaboration, a contrasting assumption may also be made that in conflict or dis-harmonious situations, energies may be expended less productively in order to manage the situation or deal with potential prejudice. Sandberg (2010), highlighted that such a situation is also likely to have consequences for an individual's collaborative health.

This correlates with the findings of this current study whereby there was the recognition, amongst the more professionally and personally mature staff, of the need to consider alternative approaches to disharmony to cope with this. These participants reported that there were too many other stressors for them to contend with without having to manage the destabilising effects of dysfunctional relationships between themselves.

Reflecting on this situation, it was interpreted that participants were prepared to altruistically prioritise the needs of the service over their own, emphasising further the presence of solidarity and cohesiveness. This therefore contrasted with Sandberg's (2010) findings in that whilst individuals' health and wellbeing may have been affected, participants were prepared to accept a degree of sacrifice, of their own needs, to maintain the collaborative health of the group.

To reach this state of being, Gajda (2004), highlighted the development of interprofessional collaboration takes time and effort to undertake as individuals jostle to establish their roles and positions. Gajda (2004) summarised this as a journey that develops in stages to maximise group similarities, reinforcing existing studies approaches to team development and recognising the needs of others.

6b.2.3 Showing an affinity for colleagues - revisited

From the completion of the first interviews within this study, the strength of feeling and concern for colleagues was clearly evident with the jostling of positions, noted above by Gajda, predominantly resolved. Through this empathy, trust, respect and support for each other, intra-group relationships had developed which were reported by the participants as creating a strong bond between colleagues. A situation also supported by the findings of Banks et al (2016).

Due to the strength of these relationships the participants and their colleagues stated that they had developed an appreciation of each other's abilities, skills and knowledge, but also where they were aware when others were experiencing difficulties and required support. These difficulties were not necessarily perceived as a negative situation, but constructed as development opportunities for the individual. From this it may be suggested that there was evidence of the presence of a positive bias in favour of those particular in-group members and their acceptance by others, with the deficits they demonstrated, potentially, viewed more flexibly than they would if presented by out-group members.

It therefore may be construed that the participants in this study recognised and tolerated some differences between themselves and their immediate colleagues (Hutchings, Hall and Loveday 2004). The findings here were comparable with those in Mickan and Rodgers' qualitative study of 202 health care practitioners in Australia. Within this, cohesion was defined as "a sense of camaraderie and involvement... generated by working together over time" (Mickan and Rodgers' 2005, p. 366).

To reach this conclusion the authors identified that their participants developed commitment to the team, a recognisable team spirit aligned through a common purpose and appreciation for each other personally and professionally with participants using tacit knowledge to reflect on how colleagues are likely to respond in particular situations as referred to

within Banks et al (2016) as intuitive performance. As in other empirical studies this was perceived to be assisted by flexible lines of communication, past experiences and the sharing of information. Similar to the findings from this study, these were determined to contribute to stability and consensus within the team.

From their study Mickan and Rodgers identified six characteristics of purpose, goals, communication, leadership, cohesion and mutual respect that they determined may be used to identify effective team working. These findings also resonate with those from the study reported in this thesis whereby the following eight characteristics were determined to assist in creating and sustaining interprofessional collaboration.

1. "Facilitating Interaction" across professional and organisational boundaries, with all staff members able to demonstrate integrity by expressing their opinions on matters pertaining to their social groups, without fear of reproach.
2. Confidence and understanding in their own and other's abilities, leading to the blurring of professional boundaries, and a commitment to learn from each other.
3. Mutual support, trust and respect between all members with altruistic behaviour and compassion for others actively demonstrated.
4. A clear vision and set of goals for the service with clarification of the norms, values and behaviours expected by members leading to the development of a collective identity.
5. The valuing of diversity of the different professions, recognising the contribution that each makes to the whole service.
6. A flatter hierarchical structure of operational staff, promoting greater equity in terms of shared status and authority.
7. <u>Dynamic Consistency</u> leading to a consistent approach to practice as participants operated autonomously but within defined

parameters.
8. Internal or external stressors creating adversity which encouraged participants to develop alliances and cohesion to manage these through coping strategies.

Table 4 – Key components of interprofessional collaboration

A study by Nancarrow et al (2013) reported on a combined investigation incorporating a systematic literature review, as well as an action research study of 253 staff working in community rehabilitation and intermediate care teams in the UK, a somewhat larger study to my own. Whilst my study comprised data pertaining to the co-construction between the participants and myself of their experiences of working collaboratively within intermediate care settings, Nancarrow et al's study entailed three systematic reviews, action research through facilitated workshops as well as participants' perceptions of what they considered to be important components of interdisciplinary working practices.

Due to the similarity of the type of teams participating in this study and my own, this is the closest comparison to the services reported on in this thesis. Similarities, were noted, in terms of the findings in that their study identified eleven characteristics that may be perceived as comparable to the stressors in my study as they were perceived by the teams involved, to be challenges to interdisciplinary practice. Seven of these were also noticeably present in my study, requiring coping strategies to manage. Unlike my study, Nancarrow et al did not offer any indication of how these challenges were managed, whilst my participants reported working together to put coping strategies in place.

Nancarrow et al's study also identified a number of themes and characteristics that the authors considered to represent interdisciplinary team work, combining findings from the study with those from the literature to create a framework of ten traits pertaining to "a good interdisciplinary team" (Nancarrow et al 2013).

Examples of these characteristics are individuals with communication skills, appropriate structures such as team meetings and procedures, a climate of trust and valuing others, respecting and understanding roles and also knowledgeable, experienced staff willing to listen to others (Nancarrow et al 2013). These five characteristics are recognisably similar to some of the findings from the emergent data in the study reported in this thesis. Nancarrow et al indicated a need for the framework they had developed to be considered in other settings to determine transferability and my study considered this type of working at an individual, rather than at a group based level, as their study had. The findings indicated similarities in approaches to interaction, even when taking into consideration differences in different contextual settings. The majority of the challenges faced, and the characteristics of a good interdisciplinary team were also pertinent for the services within my study and these were indicated thematically. Further abstraction combined them to develop the conceptual framework of the *4Cs of Interprofessional Collaboration* and the Grounded Theory that summarises this. The comparability of these findings offers reassurance for the opportunity to explore whether these are also transferable to other settings.

In contrast to the studies noted above which offered positive characteristics of collaboration, based on the literature reviewed, the variety of factors affecting them, and the lack of emphasis on the development of inter-professional relationships, Hudson (2002, p.7) described the presence of a historical legacy of “professional and interprofessional pessimism” in relation to the concept of interprofessional collaboration.

However, following his research into health and social care practitioners he, subsequently, offered a more optimistic viewpoint concluding that practitioners can actually develop a significantly different way of working to that of the traditional uni-professional boundaries, including the

creation of a shared set of values and changes to autonomy of the professions concerned (Hudson 2002) as they join forces collectively.

This resonates with the findings from the study within this thesis as, within the study reported here, the participants had limited control in the design of their services. However, they were still able to exercise a degree of autonomy at an individual or collective level as long as this was within the range expected within their categorisation and parameters of practice.

Through the process of "**Facilitating Interaction**" with others, the participants recognised the needs of their colleagues and implemented processes to develop a group identity and to ensure *Dynamic Consistency*. This contributed to the continued development of interpersonal relationships between individuals categorised as members of the same social group.

6b.2.4 Developing interpersonal relationships

Clark (2014, p. 36) suggests that "the basic building blocks of collaborative practice are the constituent professions making up the interprofessional team", with the need to recognise the diversity and different perspective of these to enable the development of interpersonal relationships.

Within the introduction of this thesis it was identified that the rationale for this study was the lack of extant empirical studies which explored the impact of interpersonal relationships on the creation of interprofessional collaboration.

Further encouragement that this was still relevant as the study was nearing completion was noted in a paper by Harrod et al (2016, p. 296) which reinforced this by suggesting the following:

*"A direct account of the **factors that affect team functioning** and **how team members are interacting to address these factors,***

*thus bringing about changes in roles, relationships and ways of providing care, **is needed**".*

This offered retrospective reassurance that the decision previously made to explore individual experiences of working across professional boundaries and organisations, in an interprofessional context, was still a pertinent one.

The findings from the study in this thesis were comparable with those of Harrod et al whose study of primary care practitioners at a clinic in America found that the service had been re-designed to create, what the authors described as, "teamlets". Whilst their findings incorporated the distribution and delegation of work, they also noted a need for individuals to understand each other's role, a theme that also emerged from this study.

Harrod et al (2016) identified that without this understanding there was a risk of "animosity" occurring between members and that key to making interprofessional practice work was to recognise the fluidity and flexibility of roles and responsibilities; again a perspective reinforced by the findings of the study explored in this thesis and that of the concept of categorisation.

Relationships between the participants were therefore influenced by the personality characteristics of them, but also the group dynamics (Hutchings, Hall and Loveday 2004). The personal and professional maturity of the participants was identified as a key factor contributing to this to determine those staff members who were perceived part of the in and out groups.

Whilst existing group members had assimilated the norms of the internalised group through the process of depersonalisation, when new members joined, consideration needed to be given to the interpersonal processes undertaken to develop their interpersonal relationships with others (Freeth 2001, Gajda 2004, Harrod 2016) and to ensure their

awareness of the cultural norms. Gittel (2012) suggests that relational coordination can offer an explanation for how organisational structures can be designed to support the development of relationships, however, this was reported as a failing strategically within the services in this study as there was limited evidence of induction programmes taking place to support new members with this.

What became clear was that instead the participants engaged in "**Facilitating Interaction**" with their colleagues to develop interpersonal relationships, seeking and sharing information through a process of situated learning. The impact of this was an important factor in the development of positive intra-group relationships whereby participants exhibited empathy and mutual understanding of their colleagues and developed strategies to achieve consensus.

By positioning themselves with others and enhancing these interpersonal relationships between practitioners, there was a reported increase in levels of trust, understanding, interactions and mutual support (Oelke, Thurston and Arthur 2013). These were influenced by a variety of factors including organisational, group specific and personal dynamics.

Green (2013), in an article based on his thesis, coins the phrase "spatial distancing" to describe how positions within an environmental and organisational structure affect these, with relative distancing, describing at a micro level, the space between individuals that can impact on the construction of professional identities.

Green used a Constructivist Grounded Theory approach to sample 28 participants from adult and mental health nursing, physiotherapy and speech therapy to explore approaches to interprofessional education, an outcome of which was that he (2013) considered that maintaining relative distancing may be used to protect those elements of the professional situation that individuals value, ultimately controlling how interactions take place, constructing four inter-related categories within this.

The notion of “relative distancing” has relevance for the study within this thesis due to the evidence of the strength of the collective identity between the group members, with the subsequent perception that this had contributed to the development of intra-group relationships.

However, Green’s findings indicated that individuals categorised themselves (and others) by their profession (Green 2013). This was not the case in the study in this thesis as participants shared concerns between themselves, irrespective of their profession, about how services were being re-designed around them. This encouraged the development of pro-active working across the different disciplines.

This led to the creation of consensus as well as a “unique team spirit” (Mickan and Rodger 2005, p. 366), camaraderie, respecting each other’s contribution and enjoying working together.

The findings in this study indicated this had created an environment where individuals could openly communicate, share information and learn from each other. There was clarity about their own, and other’s roles and an allegiance to the social group and to each other, irrespective of the profession.

Those joining the services reported evidence of a well-established, integrated and cohesive culture, and whilst initially this may have been perceived by some to be threatening to their own professional identities, it was recognised as conducive to positive working relations to rationalise these concerns and adopt the structure of practices and processes already in place, following the prototype expected of them within each social group.

6b.2.5 Developing commonalities

Whilst rhetoric suggests that inter-professional collaboration requires different professions and professionals to work together effectively, in order to achieve this, Bronstein (2003, p. 297), reinforces that “it is critical to know what constitutes and influences collaboration.” A review

of the existing literature pertaining to interprofessional collaboration has demonstrated that this is clearly variable depending on the contextualised situation.

Key characteristics of effective collaborative practice have been suggested to include participants working towards a common objective and shared vision for their service. Within this study it was evident that as well as these the participants also shared experiences, knowledge and competencies to develop commonality of approaches, norms, values and beliefs within the parameters of practice expected within their contextual situation. Aligning people in this way created *Dynamic Consistency*, enabled unity in practice and empowered them against the adversity they reported facing.

Hall (2005, p. 188) identified that each profession and team has their own unique culture comprising “values, beliefs, attitudes, customs and behaviours”, enhancing the boundaries between them (Hall 2005). In order to overcome these barriers as a result of this diversity “All team members need to be involved in creative problem solving” Freeth (2001), contributing to the emergence of a collective identity.

To achieve this required the assimilation of the cognitive maps of those external to their own profession (Wackerhausen 2009), which the junior grade participants, in this study, perceived as threatening for a period of time until they were able to feel more confident within their roles.

Considering a more holistic approach, McComb and Simpson (2014) reflect that there is currently limited evidence of the application of shared mental models within health care settings, but appreciate an increasing usage of these. A previous perception from Jeffrey and Maes (2005) was that by constructing shared mental models uniquely within their services, this would enable the participants to work collectively together through “collaborative mental modelling”. They explained this as a process by

which shared mental models are developed and modified to explain and understand reality (Mathieu et al 2000).

Shared mental models are defined as “the overlapping mental representation of knowledge by members of a team” (Van den Bossche et al 2011, p. 285). This may be considered akin to creating shared frames of reference, actively engaging with others to compare commonalities between individuals, to inform decision making within their task environment and develop mutual understanding of each other’s roles and abilities (Khalili et al 2013). This contributed to the breaking down of any preconceived professional boundaries to contribute to attaining consensus.

The findings from Mathieu et al’s (2000) study indicates that rather than formally being taught the content of shared mental models, learning emerges through natural exposure to events. As a result, though, individuals may not actually be aware of them (Senge 2006) or the effects that these have on the behaviour of individuals due to their implicitness. In order for these to be considered ‘shared’ this learning needs to be explicit with McComb and Simpson (2014) suggesting a need for a degree of similarity between individual’s perceptions of mental models, whilst recognising that individuals will perceive reality in their own subjective ways.

McComb and Simpson’s (2014) findings identified that mental models can change over time. This is akin to the Symbolic Interactionism philosophy of subjective realities and the theoretical perspective of *Dynamic Consistency* that emerged from this study. It would therefore be unrealistic to imply that each participant’s shared mental models within this study are identical but instead to recognise commonalities between them.

Previous studies have suggested that through shared mental models, where group members share language, understandings and

interpretations of what is expected of them, performance will improve (McComb and Simpson 2014, Jonker, van Riemsdijk and Vermuelen 2010) through encouraging effective group processes to positively impact on outcomes of intervention.

In an earlier article, Jeffery, Maes and Bratton-Jeffery (2005) initially challenge the proposition of mental modelling improving team performance, suggesting that there is little empirical evidence of this. Later though, in the same paper and following a review of the literature, they reach the same conclusion, as the authors above, that “shared mental models are a key to improved team performance” (Jeffery, Maes and Bratton-Jeffery 2005, p. 48) and maximising collaborative practice, a perspective also reinforced by later empirical studies. They base their determination upon five imperatives for effective collaboration (Jeffery, Maes and Bratton-Jeffery 2005).

Whilst it was not the remit of the study within this thesis to measure performance, the findings bear some similarities to those noted in the paper above in that it may be suggested that, through consensus as a result of clarifying objectives, roles, responsibilities, and processes this contributes to the attainment of consistency in approaches and paradigms and encourages collaborative practice.

The social processes to achieve this enabled participants to make sense of others’ approaches and styles, “helping people to describe, explain and predict events in their environment” (Mathieu et al 2000, p. 274). This enabled them to be more responsive to each other’s needs by producing responses consistent with those of their colleagues (Mathieu et al 2000).

Elston and Holloway’s (2001) study of practitioners in primary care highlighted that as consensus is achieved between professions and boundaries become blurred, this can reduce the strength of the professional identities of the individuals, and potentially impact on their autonomy. The findings from the study within this thesis indicate shared

learning and mutual support can help to overcome any concerns in relation to this as clinicians increase their knowledge of each other's roles and abilities. The diversity between them may be considered to be more powerful than their similarities in encouraging collaboration (Davies 2000), due to the development of a collective and enhanced identity.

Learning from others as a social process to share knowledge is a perspective that is also reinforced by Chatalalsingh and Reeves (2014, p. 514). They highlighted that behaviours within an interprofessional team focus on "communication, mutual respect, interaction and participation" to influence effective integrated practices and to enhance awareness of others.

In contrast to increasing the specialisation of each profession, such an approach offers the opportunity for generic practitioners to work across traditional professional boundaries substituting roles and identities between professions (Baxter and Brumfitt 2008) and enhancing intra-group relationships.

Within those services where boundaries do exist between professions this can promote a division of labour, leading to a demarcation of responsibilities and roles (MacNaughton et al 2013) and affecting the creation of cohesive social groups. These authors did recognise though that whilst some practitioners may feel threatened by the blurring of professional boundaries, others may positively perceive it to be a development opportunity. A degree of professional maturity is therefore required to manage the expectations of working in this way, accepting that challenge may occur from those individuals where their professional identity has not yet fully formed (Billups 2001).

The presence of professional maturity was evident in this study as many participants relished the chance to enhance their professional roles by taking on, what were perceived traditionally to be other's skills, reporting that this enabled them to practice in a more effective way, and offering a

greater degree of job satisfaction. It is accepted though that this was not a stage reached automatically but required a degree of pro-active action to attain.

Without generating common meanings during this process, confusion and disharmony may arise between practitioners leading to difficulty negotiating a consensus and solution to the situations faced. Martin-Rodriguez et al (2005) recognised that communication is therefore enabled through shared understandings and shared goals to achieve a commonality of understanding.

Through making sense of the actions of others this provided a baseline for the participants' own behaviours, with collective, negotiated meanings and positioning of relationships helping to provide the framework for creating *Dynamic Consistency*.

These meanings create the "rules" of expected behaviours for these groups with members exhibiting, what was termed by Blumer (1969, p. 70), as "joint action" to produce collectively shared norms and values, along with a corporate standard of conduct, running concurrently with that expected by the terms of their own professional code. The "collective explanations and expectations of the task" (Jeffery, Maes and Bratton-Jeffery 2005, p. 42) enabled group members to form a mutual understanding of what was required of them, leading to the creation of social order within the social groups as they worked flexibly within defined parameters.

6b.2.6 Creation of social order within teams

In accordance with the origins of Grounded Theory the philosophical perspective within the study is that of Symbolic Interactionism with its emphasis on the construction of meaning and ultimately order within the social groups under study. Within this perspective participants learn to view the world based on their interpretation of their interactions with

others, through which they develop shared meanings (Sheehan et al 2007).

The social order of each social group served the function of specifying how to behave as a member. This was set by the negotiated rules of interaction. Behaviours that are frequently demonstrated as ones that resolve any issues became taken for granted as a solution and were repeated. This was a notion Hall, Griffiths and McKenna (2013) noted echoed Darwin's theory of evolution. The risk, here, is that any changes to these behaviours may initially be perceived as unlikely to be as productive and therefore may be challenged, even though they may have potential to be positive improvements. This concurs with the perception of the fear of the unknown which may be eased through the support of others.

Billups (2001) identified that consensus is a central element of interprofessional collaboration, contributing to collective decision making. By taking into account actions of others such as these, this leads to the formation of human conduct (Blumer 1969), through responding in a way that is based on our interpretations of the situation (Gray 2014, Henn, Weinstein and Foad 2009, Charmaz 2011).

This became evident during the interviews as participants rationalised the actions of themselves and others. They articulated how by using their inner voices to interpret other's reactions, they made sense of the situation around them and, in general, responded to it in the manner expected of those with whom they interacted. Through socialisation and shared consensus, they had learnt what may be considered acceptable or unacceptable behaviours. By engaging in social processes to establish these relations and patterns of behaviour this assisted in the maintenance of consistency at interpersonal, operational and organisational levels, contributing to the enhancement of the social identity.

To achieve this, an individual can therefore not be understood in isolation to others within the same contextualised situation. The deduction is that the “self” is a product of their interaction with others and is refined accordingly as a result of ongoing participation in society (Jeon 2004).

6b.3 Summary

This sub-chapter has explored how communication and consensus were identified as emergent findings in this study contributing to creating and sustaining interprofessional collaboration.

Petri (2010, p. 74) defines the concept of collaboration as “the act of working jointly” suggesting that whilst the presence of it as an essential part of health care is recognised, it is the operationalising of it that has been a challenge.

From the co-construction of the participant’s response this did not appear to be a significant issue in this study as collaborative practice was indicative of an interdependence between practitioners, with each relying on the other to achieve an outcome greater than that they would be able to achieve on their own (Davies 2000, Bronstein 2003).

This chapter has therefore reinforced how through “**Facilitating Interaction**” participants developed social processes leading to the emergence of effective intragroup relationships and collective identities. Through maintaining open lines of communication Dynamic Consistency was constructed to be achieved as participants’ negotiated consensus within agreed parameters for their respective social groups.

Whilst achieving this, participants reported a number of internal and external stressors within their teams that impacted on them personally and professionally, affecting the stability of their social order. This following sub-chapter will explore the strategies that were put in place both individually and collectively to manage these.

Sub-chapter 6c - Developing coping strategies to facilitate collaboration

Introduction

Sub-chapter 6b has highlighted how participants in this study communicated in ways they considered as acceptable for each different contextual setting they participated in, "***Facilitating Interaction***" to manage the situations they faced. By negotiating shared meanings to create consensus and enable a collective identity to form between the participants and their colleagues, this enhanced intragroup relationships but the findings of this study are also reflective of Bond and Gittel's (2010) perspective that collaborative relationships play a role in developing coping strategies to manage environmental pressures.

The utilisation of coping strategies to manage the stressors faced by participants and their subsequent contribution to creating and sustaining interprofessional collaboration, was an unanticipated finding of this study, although Allport (1954) had previously documented the suggestion of increased cohesion in the face of adversity. To offer insight into the type of stressors articulated by the participants these are listed in tabular format in Appendix 12 indicating which service was affected by them. Chapter five has provided a further description of these using verbatim text from the interviews to document their impact on the participants.

The concept of adversity within the workplace and how this contributes to the generation of interpersonal relationships, within groups, but also to enable collaborative practice, was therefore clearly evidenced by the participants during the interviews. This will be explored further in this sub-chapter, taking into consideration the internal and external stressors articulated by the participants.

6c.1 Recognising the need for coping strategies

Coping strategies are defined as “the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimize stressful events”.

<http://www.macses.ucsf.edu/research/psychosocial/coping.php>

Accessed 20/02/2017.

The findings from this study indicated that the participants frequently experienced situations where demands were placed on them by factors, both internal and external to their groups, which they perceived as stressful, occasionally struggling to find the personal or professional resources to respond to these. This reinforces Gittel's (2008) comments of the impact that pressure within the working environment can have on workers, if they perceive these stressors as threats and particularly where there are limitations in an individual's ability to respond to them. She observed that individuals may subsequently respond to them collectively, using relational coordination as a form of resilience, or coping mechanism, to enable the participants to maintain their performance.

It was also, though, indicative of the actions undertaken by street level bureaucrats, labelled as such by Lipsky (2010), whereby public-sector workers could exercise a certain amount of discretion in implementing routines to assist them to cope with uncertainties and work pressures and contribute to policy making. The actions undertaken by them, in these situations, were perceived as positive responses that permitted individuals to manage negative situations. Lipsky's emphasis on the human element of decision making within public services and the requirement to implement and deliver policies, that they had no input in devising, was reinforced by the findings of my study whereby participants reported working under conditions of pressure to provide patients with the interventions that they required, and the organisation and commissioners expected, but often with limited resources to do so.

Martin-Rodriguez et al (2005) findings highlighted, at the time of their writing, a lack of evidence in relation to the organizational impact on the development of interprofessional collaboration. Within the context of this study, due to the adversity they perceived they faced from the strategic tier, participants suggested that they had devised creative coping strategies, on individual and collective levels, to try and minimise the impact of some of the challenges that were facing them and assist with diminishing feelings of anxiety in relation to these. Hoyle (2014) indicated that this type of behaviour was reminiscent of the emphasis on discretion used by street level bureaucrats, indicating that it is used to influence the implementation of policies made at an organisational level.

Instead of defending their professional territory, participants demonstrated altruistic behaviour (Bihari Axelsson and Axelsson 2009) "**Facilitating Interaction**" in innovative ways to offer mutual support and to develop responses to these situations. Coping strategies that had emerged were reviewed on a regular basis and adapted if required (Hall, Griffiths and McKenna, 2013). It was deduced that this was to ensure their continued relevance. In contrast, behaviours that provided less positive outcomes became less frequently used, or were potentially deemed not acceptable for use.

Green (2013, p. 36) considers that individuals "weigh up" potential outcomes before devoting personal resources to activities, suggesting that they did so based on what they considered to be most relevant to their own personal development (Green 2013). This may be perceived as a somewhat selfish concept and the findings from the study in this thesis would indicate that, in contrast to this, decisions were not just made solely at an individual level, but there was wider recognition of the needs of the in-group, and the impact that personal actions had on how this functioned.

Whilst there was limited evidence of commitment to their own organisation and strategic management structure, commitment to their

social group and to working in an integrated way with the individuals within it, was significant.

The synergy that was perceived to be achieved through the development of these intragroup relationships proved to be hugely important as decisions made at a commissioning and strategic level directed numerous episodes of service re-design, impacting on the staff at an operational level. It was the demands of the commissioners and strategic managers on these and other occasions that was reported as providing the main source of dis-satisfaction in their occupational role for the participants within this study.

Unexpectedly though, these stressors were identified as providing major contributory factors in encouraging the development of collaboration as participants reported uniting to create alliances to assist them to cope with the adversity that these challenges presented for everyday practice. By creating resilience through relational coordination (Gittell 2016) this enabled the participants to share their feelings about the stressors affecting them thereby supporting their own psychological wellbeing.

In some empirical studies, the concept of group think, where some teams are significantly cohesive and individuals suppress alternative opinions to that of the group norm in order to maintain that cohesion and avoid dissent or conflict (Billups 2001), is suggested to be present. Based on the findings from this study the strength of the intragroup relationships was so strong that there were no reports from the participants that they felt unable to share their opinions if they disagreed with others. However, whilst no evidence was articulated that the concept of group think was present, it is recognised that it may be such habitual behaviour that the "insider" may not have insight into its existence.

Putting this possibility to one side, the following sections will explore how the participants reported requiring coping strategies to manage the

stressors they considered to be affecting them during periods of transition.

6c.2 Managing change

The research aim of this study was to explore the subjective reality of the participants of their experiences of interprofessional collaboration. Individuals construct their situations in ways that are meaningful to them and these meanings are used to sustain and reproduce social reality (Crotty 2005) for the culture in which they occur. Within this study these meanings arose as a result of "**Facilitating Interaction**" with others, being negotiated and evolving over time (Andrews, 2012) to understand the phenomena. To complement Andrew's comments, it may be proposed that what may be considered to be the "truth" at one point in time may subsequently change as the phenomenon surrounding it alters and impacts upon the perception of it.

Pearson et al (2015) identified the need for effective management of change processes to enable intermediate care services to be delivered in an integrated way. Within the services in this study change was perceived to be such a constant factor in the services that it was alluded to as a "status quo". This was deemed ever present and, as a result, also impacted on the wellbeing of those involved in it. Noting a similar perspective to the participants in this study, King and Ross (2004) identified that changes in the design of roles results in psychological uncertainty for practitioners.

The need to explore the impact of the changes in the NHS legislative framework was documented by Cameron (2011) who highlighted that a greater understanding of the effects of these on subjective perceptions of professional boundaries were required. This reinforced the gap in knowledge identified during the preliminary literature review that focused a direction for study on the interpersonal elements of interprofessional collaboration.

Similar to the findings from the study in this thesis, McCallin and Bamford (2007) contended that where change is significantly disruptive, those it affects may find that they have no option but to practice in different ways. Supporting the opinion of King and Ross (2004) they reinforced that this can elevate anxiety levels due to periods of ambiguity about what was potentially required of individuals in their occupational roles. Significantly, the practitioners within this study reported apprehension about the changes that had and would be, taking place within their services.

The participants highlighted that they had no input into service redesign, effectively they were just expected to respond to, and cope with alterations to how the service would operate. This unfortunately is comparable with the findings in Nancarrow's (2007, p. 1224) interviews with staff from two intermediate care services in South Yorkshire. Findings from Nancarrow's study suggested that staff also struggled with the constantly changing expectations of the service, a situation that she described as "change fatigue".

Change is therefore perceived as potentially destabilising to group norms and stability. As a result change, when imposed upon individuals can be perceived as an internal stressor instigated by external factors.

The findings of Martin-Rodriguez et al (2005) suggested that there was a lack of evidence of organisational characteristics that encourage collaboration and this was also replicated in the study within this thesis. However, what was constructed from this data was that it was the responses to the organisation's actions that contributed to actively encouraging participants to support each other, putting collective and individual coping strategies in place to manage the demands that they faced from the organisation and commissioners.

More recently, this situation was reinforced by Jupp (2015) who argued that the frequent changes in primary care over the last two decades have

led to staff having difficulty in coping with the previous reform before a new one is executed, a situation alluded to in many participant's responses. The participants reported facing a situation similar to what Toffler (1971, p. 2) termed "future shock". He used this to describe where "stress and disorientation are induced in individuals by subjecting them to too much change in too short a time".

In spite of Toffler's recognition nearly 50 years ago of the potential negative impact of persistent change, and that it can destabilise existing lines of communication, interpersonal relationships and processes, thereby undermining collaboration, reforms have continued to proliferate. There has been a continuation of the emphasis of previous policies on promoting the introduction of interprofessional collaboration, and in particular enhanced integrated working between health and social care (DH 2012).

Based on the perceptions of the individuals within this study, Toffler's concept of "future shock" may therefore be considered a pertinent description of modern day health and social care services, affecting many of those employed within these. Hence, the identified need for participants to put coping strategies in place so that they can manage their working situations.

During the course of reviewing the literature a comparable concept of Toffler's "future shock" was identified in the form of the more contemporary term "liquid life" which was noted in a paper by Bleakley (2013, p. 18). This concept was attributed to Bauman (2007) and was defined as a:

"society in which the conditions under which its members act change faster than it takes the ways of acting to consolidate into habits and routines".

Bleakley enhanced this by stating that instead of stability there is a “permanent state of fluidity” (2013, p. 19), which brings with it uncertainty, particularly in relation to what the concept “team” actually means due to a multitude of definitions. This resonated so accurately with the findings from this study whereby change was considered to be a constant feature, with participants struggling to maintain an element of stability within their services whilst contending with the changes that they were expected to operationalise. This reinforced further the interpretation of *Dynamic Consistency* to reflect the behaviours articulated, as participants practiced within the internalised norms of the service, whilst the situation around them was in a state of flux (Bleakley 2013).

Paradigm shifts (Covey 1989) were therefore required to consolidate and confirm new ways of working, to create meaning and order and make sense of why the changes were suggested. This required individuals involved to review their situations from a different perspective to re-frame their existing paradigms, and make changes to practice by adapting to the new ways of working and adjusting previously established ways (Wackerhausen 2009). Within the construct of the in-group, this was facilitated by clear, supportive interactions between the members as noted in the previous sub-chapter.

Therefore, whilst Atkins (1998, p. 306) suggested that interpersonal interactions can “impede or facilitate the process of change”, the reports from the participants in this study would suggest evidence of facilitation rather than impediment, as the relationships between them provided them with the motivation to unite against adversity, creating a cohesive group that was working towards a common purpose of operationalising the change.

6c.3 Emotional resilience

In accordance with many studies relating to interprofessional collaboration, the results of Jackson, Firtko and Edenborough’s (2007)

literature review suggested ambiguity in that the term resilience has not acquired a common definition. They do, though, recognise the interdependency between resilience and adversity. For the purposes of this study emotional resilience is therefore perceived to reflect an individual's ability to respond or recover from situations of adversity or stress.

The emergent findings suggest that irrespective of their true feelings the participants recognised that they still needed to behave professionally when undertaking interventions with service users and to mask their own emotions. This concept has been termed emotional labour (Ashforth and Humphrey 1993, Brotheridge and Lee 2003, Didier Truchot and Borteyron 2015) and is the process by which practitioners display expected, normative behaviours for their roles, through the process of acting, regulating their true feelings to perform in a manner expected by the culture of the team and profession (Brotheridge and Lee 2003).

In addition, through demonstrating the process of professional maturation, professionals may develop strategies for surface and deep acting to assist with suppressing their emotions and to ensure continued consistency of practice (Ashforth and Humphrey 1993, Martinez-Inigo et al 2007). These involve masking their true feelings, in the case of surface acting, by replacing these with displayed feelings more appropriate to the situation, or altering one's own feelings in the case of deep acting by trying to bring them into alignment with those required for the situation (Brotheridge and Lee 2003).

Martinez-Inigo et al (2007) highlight that at the time of their paper there was a lack of empirical evidence between emotional regulation and emotional exhaustion, but accept that there is likely to be negative connotations where the cultural expectation is for the presentation of positive emotions. They considered emotional regulation to require less

effort than deep acting with surface acting requiring less effort than this (Martinez-Inigo et al 2007).

Irrespective of which option is undertaken, both can lead to emotional labour and psychological strain on the individual, depleting energy resources (Brotheridge and Lee 2003) and potentially leading to burnout (Didier Truchot and Borteyron 2015). Martinez-Inigo et al (2007) did suggest though that contributing to the management of this were the rewarding interpersonal relationships between colleagues, a factor already presented earlier as evident between the participants in this study.

Whilst a number of participants admitted to feeling under-valued by strategic managers and dis-satisfied in their role, they reported reflecting on their concerns and sharing them with colleagues. This allowed participants to increase their awareness of their own and other's needs. McCallin and Bamford (2007, p. 386), reported that an "effective team needs both emotional intelligence and expertise" to encourage integrated practice, with the five domains of emotional intelligence being "self-knowledge, self-awareness, social sensitivity, empathy and ability to communicate successfully with others" (Covey 2004, p. 51, McCallin and Bamford 2007, p. 387).

The relevance of this is that behaving in this way impacted on how individuals managed their intragroup relationships and was typified by recurring comments from participants advocating a need to "be kind to others", to support, value and care for colleagues. Jackson, Firtko and Edenborough (2007, p. 6) proposed "building positive, nurturing professional relationships" as a strategy contributing to the development of personal resilience and this is built upon by the findings from this study as the networks of individuals guided and supported each other.

As in the case of the study within this thesis, when collaborative practice is effective it can offer mutual support for each participating member. However, when difficulties arise it can be quite a time consuming and

costly (in terms of physical and personal resources), situation to manage (Sandberg 2010), particularly when practitioners feel under threat. This was a factor that was recognised by the participants and proactively managed by them to maintain order and stability.

This is particularly important as it has already been noted that following a period of change, professionals may be required to work differently. If they were previously assured in their practice, this may result in anxiety and uncertainty due to the disruption it can bring to their internalised identities (Robinson and Cottrell 2005) and subsequently impact on their collaborative health.

A potential outcome of this is that dissonance may therefore occur when an individual has internalised beliefs that may be in conflict with each other and with the behaviours that they feel obliged to present in particular situations, which can lead to feelings of unease (Guirdman 1990, Walsh and Wiggins 2003). This was particularly pertinent within this study in relation to the stressors faced by the individuals.

6c.3.1 Working through adversity

Adversity in the workplace may be considered as “any negative, stressful, traumatic, or difficult situation or episode of hardship that is encountered in the occupational setting” (Jackson, Firtko and Edenborough 2007, p. 3).

The relevance within this study is that whilst the participants did not suggest significant internal conflict, there was mention of some areas of disharmony, both intragroup and intergroup. Conflict resolution strategies were alluded to including the use of compromise, accommodating others and collaboration (Buchanan and Huczynski 1997). Examples provided were rationalised by participants with reasons given for why others had behaved in the way that they had, usually attributed to a stressor. They were also recognised as short lived incidents, suggesting disharmony was proactively managed.

In their literature review Xyrichis and Lowton (2008) identified only one study that reported a lack of conflict between members. Unlike the numerous other empirical studies in the literature, destabilisation of relationships did not materialise as a problem within the study in this thesis as participants reported that when disharmony occurred they felt that they were able to work through this by maintaining open communication links with each other. This is comparable with Robinson and Cottrell (2005), whose participants developed creative ways of working to engage with each other and overcome challenges.

A similar observation was also made by McCallin and Bamford (2007, p. 387) who recognised the effort required in handling “dysfunctional team members”. However, within the study in this thesis, rather than dysfunctional intragroup relationships, there was evidence of some continued disharmony with members of the wider network with which they had contact, particularly in relation to those making referrals to the service. These were individuals perceived as external to the participant’s own social group.

Whilst the participants in McCallin and Bamford’s study were found to ignore or withdraw from others, deny the presence of confrontation, or, a more drastic coping strategy was to leave the team, this contrasted with the in-group findings from the study in this thesis, whereby the diversity of personalities was suggested to be recognised and accepted due to the strength of the collective identity of the group members.

Through the cohesion created by this, the group members considered themselves to be emotionally resilient to overcome adversity with behaviours akin to those which may be historically described as the “Blitz Spirit”.

Without wishing to detract from the fortitude shown by the British population during the incessant bombing of the British Isles during World War II, and excluding the element of danger – hence the use of square

brackets in the definition below, the use of the phrase “Blitz Spirit” was considered a pertinent analogy for the experiences faced by the participants, due to the adversity they reported encountering on a daily basis:

“British stoicism and determination in a difficult [or dangerous] situation, especially as displayed by a group of people.”

<http://www.oxforddictionaries.com/definition/english/blitz-spirit>

Accessed 8/11/2016

Participants described situations where they felt they were placed under increasing and unacceptable, psychological and physical strain by the demands placed upon them within their roles. Through the commonalities of experience, members of the in-group united to support each other in managing these situations, a situation Bihari Axelsson and Axelsson (2009,) noted required professional maturity.

An example within the study in this thesis of a significant barrier, was reported between those making a referral to the service and the members of staff working within the intermediate care services. There were frequent reports in the participant’s interviews of inaccurate information provided by referrers to the services. To manage this situation, participants identified a need to be cautious in relation to any information provided by those referring to them. They stated that they preferred to spend time, once the client had been admitted to the service, double checking the patient’s medical records as they perceived this was a way of protecting each other by obtaining correct factual information upon which to implement a rehabilitation programme.

This was representative of the territorial behaviour noted by Bihari Axelsson and Axelsson (2009), whereby professional groups promoted and, in this case, protected their professional territories, but also protected other in-group members against those who were outside of

their area of work. There was also relevance here to the contact hypothesis of Allport in relation to prejudice applied to the out-group, due to the challenge in managing interactions with them.

6c.3.2 Facing challenge from others

In their literature review, D'Amour et al (2005) identified a need to promote collaboration to newly qualified practitioners before their professional identity is developed to such an extent that they resist this, or before they perceive interprofessional collaboration as similar to the "act of co-operating with an enemy that is occupying your territory" (cited in Petri 2010, p. 74).

Continuing this theme, MacNaughton, Chreim and Bourgeault (2013) observed the presence of power struggles in their findings, highlighting that professional boundaries may be elevated through concern about others taking on, or encroaching on roles individuals perceive to be theirs.

The implication of this pessimistic approach is that working in an interprofessional way may therefore challenge the social order that individuals have come to rely on. In contrast, Green (2013) observed that collaborative practice moves practitioners away from a bounded format supported by their professional and regulatory bodies (Green 2013). He suggests that a way to overcome these boundaries is through the development of allegiances and networks, a situation also supported by the findings from the study in this thesis. However, this requires individuals to be accepting of change to their own and other's roles (Harrod et al 2016), suggesting the presence of consensus.

In contrast, disharmony may lead to innovative service improvements by challenging the status quo, however in such situations practitioners also may withdraw from collaborating (Freeth 2001), fearful that to work in a different way may potentially dilute their status within the service. For some, the change to working across traditional professional boundaries may lead to increasing uncertainty about what the future may hold for

them, particularly should they perceive these as threats to their professional identity (Khalili 2013). This may lead them to withdraw into their traditional role creating a tribalistic reaction, (Wilson and Pirrie 2000, Hutchings, Hall and Loveday 2004).

Similarly, Khalili (2013, p. 452) identified “turf protection” behaviours as one of the barriers to interprofessional collaboration. Whilst evidence of this was significantly lacking amongst the practitioners within the study in this thesis, the junior grade staff did report that at a post registration level, they became aware that there would be an expectation that they would take on tasks that may be perceived to be the remit of another profession.

As they stated that they had not expected the extent of this, the repercussion was that some initially felt vulnerable and that they were working outside of their comfort zone. They reported receiving support from their immediate colleagues to overcome and cope with their “professional preciousness”, i.e. their desire to retain control of tasks that they perceived to be their sole remit. This may be perceived to reinforce the extent of cohesion evident between members of the in-groups.

Professional preciousness was a term devised for use in this study that related to where professionals exhibited protectionist behaviour in relation to their professional roles. It applied where participants had a perception that other professions were taking on tasks that were traditionally theirs, and where they had a sense that professional boundaries had been crossed as a result.

In support of this, Hutchings, Hall and Loveday (2004) highlight that the different variables of professional grade, age and skill mix can impact on interpersonal relations and therefore whether the concept of professional preciousness is demonstrated. From the findings of this study, the participants who were employed in a higher grade, or who had worked in the service for a number of years, or who had greater life experience,

were less reluctant and engaged more freely with working across traditional professional boundaries. The outcome of this is that some reported that interprofessional collaboration had become such a habitualised form of practice that it was second nature.

However, to achieve this stage it is recognised that working in a collaborative way with others with different cognitive professional maps is a challenging concept (McCallin and McCallin 2009). Hall (2005) advised that during times of stress, individuals could retreat into their own professional silos with barriers to interprofessional collaboration occurring where individuals are unable to consider that there is an alternative world view to their own.

The significance of this is that during the process of developing inter-group relationships, individuals may therefore initially focus their efforts on their own profession, prior to engaging with others (Hutchings, Scammell and Quinney 2013). Upon developing confidence in their own, and other's abilities, and in their social identities, they may find this engagement less of a threatening possibility leading to the development of *Dynamic Consistency*, having negotiated accepted parameters of practice. This also subsequently altered the boundaries of the in-group by allowing access to this by others who share similar commonalities but were not part of the same profession.

Jones (2007, p. 355) defined boundaries as "clear dividing lines between areas of different ownership or shared areas of contact". It may be suggested, from this, that boundaries may lead to conflict as competition to lay claim to particular areas of expertise develops. This philosophy contrasted with that expected by UK government policies following the increased emphasis on collaborative working over the last 20 years encouraged role and professional boundaries to be more flexible.

In developing relationships to overcome existing boundaries, participants demonstrated that it was important for them to support others and also to

feel supported. This was achieved through communicating to achieve consensus, negotiating meanings to diffuse potentially difficult situations where divergence of opinion occurred and was assisted by taking into consideration the values and perspectives of their colleagues.

6c.3.3 Mutual consideration of others

In seeking mutual understanding of other's perspectives participants recognised that their own subjective realities may differ from those experienced by their colleagues (Covey 1999). Therefore, mutual understanding was achieved through a process of "**Facilitating Interaction**" to negotiate meanings.

By reflecting retrospectively on the behaviour demonstrated by oneself and others this shaped the prototype required of group members, which in turn shaped future experiences and actions as people gained insight into other people and how they work.

A strong framework of trust and respect for others is therefore required to facilitate collaboration, with the relationship dynamics between individuals considered by D'Amour et al (2005) to be an important factor in this. These interactions between individuals may be perceived as enabling professional boundaries to be overcome.

Contributing to achieving these, within this study, was the emotional maturity of the participants and their willingness to work in a different way to that they have initially being professionally socialised to expect (Billups 2001). As a result, collaborative practice was predominantly welcomed as an innovative approach, supporting the creation of overlapping roles and blurred bounded working, by those confident in their own social identity (Suter et al 2009).

Whilst it may be perceived that a lack of emotional maturity, and a strict rigidity to professional specialisms can lead to interprofessional practice being considered as a threat, the findings from this study indicated that

once participants recognised, understood and felt confident in their own role they were able to work across professional boundaries without feeling threatened or jealous of others, relinquishing their "ownership" of some of their traditional professional skills and knowledge. The collective identity became greater than the individual one.

To assist with the development of this, Quinlan and Roberston (2010) observed that mutual understanding was achieved through the exchange of knowledge between individuals, describing communication as "central to human relationships as it provides the vehicle through which we share ideas, co-ordinate actions and build social structures".

This contrasted with an earlier study by McCallin and Bamford (2007), who had found that their participants failed to recognise this emotional aspect of working with others, keeping their distance from colleagues.

The findings from MacNaughton's study (2013) slotted between the two mentioned above, reinforcing that people could be collaborative but still maintain an element of autonomy. This was a finding also reinforced in my study as practitioners maintained their core skills whilst undertaking blurred boundary working too. This led to a greater understanding of the skills and competencies of other professions and the generation of interpersonal relationships, thereby enhancing cohesion and group allegiances, a factor also reinforced by Gittel (2012, p. 20) who summarised this as "respect for the competence of others creates a powerful bond, and is integral to the effective coordination of highly interdependent work."

The recognition of other's points of view, even if they may differ to their own, suggested evidence of emotional intelligence in practice as highlighted in McCallin and Bamford's (2007) study along with the valuing of the contribution of colleagues. Whilst supporting their colleagues at an interpersonal level, this behaviour was recognised by participants to be part of their responsibility to promote, and maintain, anticipated

standards of behaviour, conduct and practices and therefore to actively encourage consistency of cultural expectations within negotiated parameters.

6c.4 Summary

This sub-chapter has highlighted how the presence of stressors within the services participating in this study unexpectedly contributed to the development of interprofessional collaboration through the creation of individual and collectively oriented coping strategies to manage these.

Rather than a pessimistic view of collaboration, this study has therefore suggested the presence of an optimistic one with examples of close working relationships and practices that the participants genuinely reported being engaged with and which was perceived to benefit them, their colleagues, their organisations, but ultimately their service users.

This fits with Hudson's (2002) hypothesis suggesting that members of different professions working together may have more in common with each other than colleagues from the same profession, but also that socialisation to a team may have a stronger effect than to an individual professional identity.

The findings from this study therefore concur with Hudson's conclusion due to the strength of identification with specific social groups. The construction of social identities and professional socialisation to help define consistencies of approach, clarified for the participants what was expected of them during the performance of their operational role leading to depersonalisation and an enhancement of their collective identities. This recognition of the value of ensuring consistency and the contribution of situated learning to maintain and develop this will be explored further in the following sub-chapter.

Sub-chapter 6d – Achieving consistency in collaboration

Introduction

The previous sub-chapters in chapter 6 have presented the theory emerging from this study and have explored, so far, three of the 4Cs of interprofessional collaboration; communication, consensus and coping strategies that emerged from the findings.

The importance of open and transparent lines of communication have been identified by King and Ross (2004) as a key factor to enabling collaborative working, leading to the establishment of shared meaning and consensus by negotiation between individuals (Weick 2001, Miliken et al 2012), through the process of "***Facilitating Interaction***".

This contributed to the establishment of integrated working between the participants' through the formation of individual and collective coping strategies to manage the circumstances faced by the participants and perceived, by them, as internal or external stressors.

The social processes, undertaken to respond to these stressors, led to the development of consistent approaches to practice as participants defined their identities based on memberships of their social groups (Trepte 2006).

This sub-chapter will conclude the discussion of the study's findings through further exploration of the social processes undertaken to achieve this stability and dependability. It commences with the consideration of how the concept of *Dynamic Consistency* is defined for the purposes of this study.

6d.1 Dynamic Consistency

Charmaz (2014) noted that within Constructivist Grounded Theory a reflexive stance is taken towards the research processes and products, with the researcher considering how their theories evolve. Within this

study, "**Facilitating Interaction**" was abstracted as the core category, and this was implicit in its presence within the data, connecting all the categories and sub-categories. However, reflecting on the social processes that comprised this, led me to question further the reasons why and how the participants behaved in the way that they reported.

This reflection led to the theoretical construction of the 4Cs of Interprofessional Collaboration, recognising that the participants communicated with each other to achieve consensus, applying coping strategies to maintain consistency. The flexible nature of these approaches reinforced that interprofessional collaboration, within the services in this study, was not a constant state of being, but a state of flux due to the number of internal and external variables affecting it.

Reflecting on this, the label Dynamic Consistency was therefore considered an appropriate descriptor of this state. This was perceived to complement the theoretical constructions of the study, but was also my interpretation of the strategies utilised by the participants, that were applicable to the social processes which contributed to the creation of collaborative practice within the services. This section will summarise how this is represented within the findings that emerged during the analysis of the data.

For the purposes of this study the term *Dynamic* was characterised as a proactive way of participants carrying out actions according to the demands of the situation, recognising, in doing so, the need for flexibility and adaptability due to the multitude of variables that were impacting on them. It relates to any circumstance that the participants may need to respond to, including social, cognitive, affective or environmental issues and may involve reviewing and modifying existing processes.

Dynamic was juxta positioned to the term *Consistency* due to the recognition of the latter term as a descriptor for the means of maintaining uniformity and reliability within the systems utilised within the services

and also its presence within the 4Cs of Interprofessional Collaboration. When considering the emergent findings, a particularly pertinent definition of consistency was obtained from www.dictionary.cambridge.org which defined it as:

“the quality of always behaving or performing in a similar way, or of always happening in a similar way”

Accessed 4/4/17.

The concept of Dynamic Consistency therefore pertained to, not just the actions undertaken by the participants to work autonomously, but also their behaviours, attitudes, norms and values within the expected parameters of practice for their contextualised settings. This enabled the participants, in the same social group, to identify with each other (Stets and Burke 2000).

In contrast to the implicit nature of “**Facilitating Interaction**”, Dynamic Consistency was present at a tacit level of operation, articulated by the participants as an accepted form of practice that had become habitual, as participants highlighted an acceptance of working autonomously but within agreed and accepted parameters.

Whilst consistency in interprofessional collaboration has been alluded to in the form of collective visions and sense of purpose, commonality of language and processes, as well as shared documentation (Webster 2002, Sheehan et al 2007, Bihari Axelsson and Axelsson 2009), a review of the extant literature was unable to locate any evidence that Dynamic Consistency was a term that had previously been applied to the phenomenon. Reflecting on the data though, it was determined to be a particularly relevant explanation for the strategies utilised by the participants to create and sustain interprofessional collaboration and intragroup relationships between the participants in this study and their colleagues.

This was reinforced by the perception, from the interviews, that once the group identity was established, it was deemed to be in the best interests of the service, the organisation, and the service users that this was maintained through the perpetuation of habits, behaviours and processes. This contributed to a categorisation of participants, providing a structure under which they would operate (Trepte 2006). It also ensured conformity as individuals defined themselves in relation to their group and, as a result, operated consistently in accordance with the expectations of membership of this.

6d.2 Interprofessional education

Finch (2000, p. 1138) proposed that the NHS wants newly qualified student practitioners who are prepared to be able to “know about”, “work with” and “substitute for” colleagues of other professions when required. She does, however, question which of these aspects education providers would be able to deliver due to the traditional, historical demarcations between different occupational groups. She concluded that this would require curriculum designers, within universities, to adapt and develop their educational programmes to meet these requirements and to overcome the barriers set by the differing demands of the different professional accrediting bodies.

Rather than placing the emphasis for meeting these requirements solely on formal academic learning, Finch instead reinforced the opportunities for learning to take place whilst on placement in clinical settings where students could observe others and learn from them. Indeed, the WHO (2010, p. 10) offered a definition of interprofessional education (IPE) as “occasions when two or more professions learn from and about each other to improve collaboration and the quality of care”, developing the relevant competence, knowledge and values to encourage collaboration. Barr et al (2016, p. 549) highlighted the value of this would be to “promote flexible, coordinated, complementary, patient-centred and cost effective collaboration in interprofessional teams”.

Indicative of many empirical studies, the emphasis in this quote is therefore reflective of the impact of IPE on outcomes for the service and less so on the individuals working within them. Rather than considering IPE as only applying to formal education, recognition is required of the impact of learning within the context of, and specific to, the situation. This was supported by Barr et al (2016, p. 549), in the form of “socially constructed learning”, as a means of encouraging “interdependence in practice”, taking into consideration the potential impact on individuals.

The value of learning in practice was also reinforced by D’amour and Oandasan (2009) who commented that there is limited opportunity for practitioners to learn collaborative practice at an undergraduate level. Instead they too emphasised the extent of learning that takes place within the practice setting, with Lipsky (2010) also concurring that training within this setting is more likely to be more effective to that in classroom based settings. He considered this to be the result of it taking place within the context of problem-solving situations.

The findings from the study within this thesis reinforce this emphasis as professional knowledge, practice and competencies were reported to be shared on an informal basis, and negotiated during the process of **“Facilitating Interaction”** between the participants and their colleagues. These exchanges took place within the contextualised situation (Brown, Collins and Duguid 1989, Lave and Wenger 1991, Machles 2003).

The impact of this interaction can lead to the construction of situated learning (McCallin and McCallin 2009), as newly acquired information combined with previous experiences and knowledge. This assisted individuals to make sense of a situation, consider alternative points of view and create new mental models (Machles 2003, Wenger 2008, Goel 2010). Situated learning therefore “reproduces and transforms the social structure in which it takes place” (Wenger 2008, p.13).

6d.2.1 Reinforcing professional practice through learning together

In support of this style of learning and, in contrast, with what may be expected from rigid, formal learning, Mohaupt et al (2012, p. 370) highlight the interactive element of IPE, in which the “intent is for participants to learn with, from and about each other”. There is recognition that this can be affected by barriers between individuals and organisations with a need to ensure that the environment feels safe for them to learn in this way (Nisbet, Dunn and Lincoln 2015).

Therefore, through IPE in the context of situated learning, it is suggested that individuals develop “the practices and identities appropriate to that community” (Handley et al 2006, p. 642). Individuals interact to learn together and influence each other through the process of working together.

This was supported by Nisbet, Dunn and Lincoln’s (2015) findings that the potential for interprofessional learning was strengthened through interaction with others. This also resonates with the findings from the study in this thesis, with participants recognising that whilst undergraduate IPE enabled them to become a professional, it was actually the process of learning from others, once in post, that provided them with the skills to function in their occupational roles and social groups. The development of interprofessional relationships and mutual respect for the competence of others, was considered by Gittell (2012) as integral to the creation of a powerful bond between colleagues, and enhanced integrated working and this was also reinforced by the findings from this study.

Therefore, whilst numerous authors including Masterson (2002), the WHO (2010), Khalili et al (2103), in their paper on Canadian educational programmes and Green (2013) all report the role that IPE plays in promoting interprofessional practice at an undergraduate level and, the perception that it assists in breaking down traditional professional boundaries, there was little evidence of its effectiveness in enabling

collaboration between the participants in this study. Instead work placed IPE was perceived as more effective than university based education to do so.

Whilst the findings from Nancarrow et al's (2013) study reinforced this perspective by highlighting the value in teams investing time in service development activities, within the study in this thesis it was determined that this was undertaken without any formal support or direction from those at a strategic level. Instead operational staff guided this themselves informally learning, explicitly or implicitly, from those with whom they interacted.

It may therefore be contended that situated learning shares similarities to the Symbolic Interactionist framework and to the Constructivist Grounded Theory methodology used in this study. All of these interpret the content of the interaction, within the context of the situation, to create meaning and share experiences and understanding (Lave and Wenger 1991). This leads to the formation of a collective memory for the social group to assist in the development of habits and rituals, enabling them to maintain order and consistency in their roles. Similar to the data obtained during this study, the generation of meaning is therefore grounded in the situation in which it occurs (Day 2006).

A more advanced form of this knowledge transfer was termed a "community of practice" as the group members mutually engage with each other using a shared repertoire to share their knowledge and skills with others (Roberts 2006), complementing those that they already had. Individuals use these as a baseline to develop a mutual understanding of how collaborative practice can develop within the context of the practice setting, but also, by matching their behaviours to that expected within the group, this was considered to reinforce the acceptance and self-worth of members.

In exploring this way of working, it was evident, within this study, that it was not just knowledge, but also individual's behaviours that were affected through the interactions between colleagues. Attitudes and beliefs were reviewed and adapted to meet those expected of someone within that specific culture and shared understandings and meanings were agreed and become habitual (Hall, Griffiths and McKenna, 2013). This resulted in the development of tacit "rules" for how each social group would work, highlighting the learning of standards of practice and processes. This can be construed as a powerful tool in ensuring consistency and predictability of approach, supported by Sims, Hewitt and Harris' (2015) findings that learning may occur unconsciously.

A key finding was that, whilst the participants within this study indicated that they maintained the core skills of their profession, greater flexibility of their roles was evident through the process of learning from others, leading to a blurring of boundaries between them, with areas of overlap between what each could offer the service. Participants extended their roles, through this and, most importantly, had the authorisation of others to do so, thereby ensuring that it was a mutually agreed and supported approach. This was comparable with the findings of Nancarrow's (2004) study into "Dynamic role boundaries in intermediate care services".

Nancarrow suggested that "role overlap has the potential to benefit a range of stakeholders" (Nancarrow 2004, p. 150). Within this study, this way of working has contributed to a degree of stability in the social group, encouraging group allegiance, rather than just professional alliances and was comparable with the cohesion noted by Mikan and Rodger (2005).

Also in support of this, Brown, Collins and Dugid (1989) suggested that individuals working together synergistically as a group create a greater solution collectively than those working in other ways. This therefore may be construed as offering benefits to the organisation as well as individuals. Durose (2011) notes that workers have to interpret policy, and make decisions on how to implement it in ways that are appropriate

and beneficial to the setting in which they provide interventions. This may be considered to be indicative of Lipsky's (2010) notion of street level bureaucrats whereby operational staff working on the front line used their discretion when undertaking their role. During this process meanings are reviewed and either replicated or adapted in a constant process of interaction (Lave and Wenger 1991).

Lipsky's core argument is that the use of discretion within welfare bureaucracies was unavoidable as practitioners made judgements in relation to how resources are utilised (Hoyle 2014). This enabled them to also devise coping strategies and strategies for interaction to assist in this decision making (Taylor and Kelly 2006) and is a particularly relevant concept in light of the volume of change that each service had experienced and were expected to operationalise. It is also pertinent of the concept of *Dynamic Consistency* that emerged from this study as the participants worked within negotiated parameters of practice.

Enhanced collaboration through the sharing of values, skills and knowledge as well as the potential for joint problem solving, is therefore perceived not just to be of benefit to the collective group in terms of better use of resources and improved client care, but also to benefit practitioner's individual learning and development, and ensure they meet the standards required by their regulatory bodies (Morison, Johnston and Stevenson (2010).

What was especially evident in the findings, from the study within this thesis, was that the ongoing process of creating and sustaining collaboration was due to individuals analysing, consciously and unconsciously, their interactions with others in these settings in order to categorise them, learn from these experiences and adapt them accordingly to maintain consistency within the collective through sharing common goals.

A brief description of the historical evolution of professionalism will now be considered to gain an appreciation of how modern day professional practice has emerged from uni-professional forms of working to enable this greater flexibility of practice. The impact of this is that it has contributed to the development and sustainability of interprofessional collaboration within the services taking part in this study.

6d.3 Professionalism

The concept of professionalism developed during the 19th and early 20th centuries as monopolies over specific practices and expertise, gradually replaced a more generic approach (Irvine et al 2002, Hall 2005).

Professional groups developed their own unique paradigms and therefore specialisms.

Wilson and Pirrie (2000, p. 18), Hammick et al (2009, p. 17), Cribb and Gerwitz (2015, p. 29), determined the term profession as a “group of people who have undertaken a given programme of education and or training” as defined by the regulatory body of that profession. As a result of which, they receive authorisation to join an exclusive party with restricted access rights and are regulated by statutory and professional bodies based on codes of conduct, standards and ethics (Hutchings, Hall and Loveday 2004).

According to Clouston and Westcott (2005, p. 103), “professionalism is the characteristic thinking and behaviour of professionals” specifically attributed to those with professional training, leading to the achievement of professional status and along with this an element of control of these competencies over others. Irvine et al (2002) suggested that, as a result, this contributed to a myopic perspective of individual professions.

All the participants in this study were members of regulated professional groups. The effects of the re-design of services, reported within this study by them, led to a recognition that, for the participants, it was sometimes a difficult balancing act between maintaining professional integrity and

their statutory requirements and the demands that an organisation was placing on staff to work differently. Cribb and Gerwitz (2015), supported this by advocating that to be a professional is to be “a custodian of a certain kind of role” that may be challenged during the process of service re-design whilst occupants of the role try to understand the social position and pressures that contribute to it.

Whilst interacting with others, if participants had considered themselves to be curtailed by their uni-professional background, this may have created intragroup difficulties, however, within this study, rather than individuals being categorised solely in terms of their professional identity, there was evidence that they had internalised the norms of the wider collective. As a result, a more generic form of professional working was therefore evident.

The latter may be considered to be a success of the introduction of competency frameworks within the services at an operational level. These provided specific and documented protocols for clinical activities and link with Roberts (2006) findings that the boundaries between the professionals working in such an integrated way are therefore more likely to be flexible and permeable than within those working in uni-professional practice. This was also reinforced by the reports from the participants in this study.

There was consistency in terms of standards of practice with different professionals undertaking tasks interchangeably in certain situations. Through the use of competency frameworks this reinforced the prototypical behaviour expected within each social group (Hornsey 2008) as participants took on tasks that, in other services, may be considered to be traditionally the domain of other professions.

This contrasts with traditional education processes which have been perceived to result in reinforcing uni-professional identities. These have historically been perceived to be creating a barrier to working

interprofessionally as concluded by Elston and Holloway's (2001) findings, as practitioners are socialised to be specialist practitioners in their field, trained to perform autonomously. The evolution of professions in this way was considered to encourage impermeable boundaries between them, a situation Beattie (1995, p. 11) and later Hutchings, Hall and Loveday (2004, p. 120) described as 'tribalism'.

Tribalism can occur (Webster 2002, Baxter and Brumfitt 2008) when practitioners become overprotective of what they perceive to be their roles and specialist areas, stating a unique claim to these, rather than supporting a culture of integration. The perspective of overprotectiveness towards their own profession/role was a concept described as "professional preciousness" earlier in this thesis and was highlighted as specifically present in responses from junior grade staff.

In working in this way, individuals are perceived to be defending their territory against threats from others (Bihari Axelsson and Axelsson 2009), who may wish to encroach on it, thereby preserving their status as dominant provider. However, Webster (2002) considered that in order for collaboration to work successfully tribalism has no place if all practitioners are to be valued equally.

To overcome this, Bihari Axelsson and Axelsson (2009) argue that professions need to put the interests of the social group above that of their own and share their territory. This has relevance here as reinforcing the interests of the collective was a form of practice that was recognisably evident within this study.

6d.3.1 Professional socialisation

Historically, the national legislative framework within the UK has advocated for collaboration and permeable professional boundaries, however, proactive work is required to action this and redesign clinical roles and services to meet the demands of the managerial and political reforms.

Within the political rhetoric, it can be reasoned that an assumption was made that clinicians would be willing to work across professional boundaries, challenging their traditional professional socialisation that was reinforced through uni-professional undergraduate education. The implication, of completing their professional socialisation, at this early stage of their career, was that each profession would diversify in terms of culture, values, beliefs and behaviours to that of others (Hall 2005). A way of overcoming these differences was therefore required if integrated working was to be a success.

An emphasis on uni-professional working is therefore not considered to be conducive to collaborative practice. Putting this into context for this study, participants highlighted that new members joining the team were supported in assimilating the existing, integrated style of working, through the process of socialisation into the social groups agreed parameters of practice. Whilst some participants reported an initial reluctance to do so, to the extent that was expected of them, all reported that they did eventually conform to the accepted cultural behaviours through the process of being influenced by others (Hornsey 2008).

Some did recognise though, feeling uncomfortable in their roles until they had reached this point of adapting to the norm. This was due to, what they perceived to be recognisable, albeit, often small differences, between themselves and others. The desire for acceptance by others was a key factor in overcoming this and encouraging participants to internalise the group membership. Acceptance was achieved when they were perceived by others to be what Wackerhausen (2009, p. 459) described as "one of our kind".

To reach this stage, individuals adopted the implicit and explicit behaviours expected of a member of the group (Wackerhausen 2009) in which they were participating. McPherson (2001) therefore reinforced interprofessional collaboration to be part of a continuation of learning at

all stages of undergraduate and post graduate levels as participants progress in their careers.

Pre-registration education has been mentioned previously. The role of it is to prepare students for their forthcoming clinical role as a qualified practitioner. Pre-registration education socialises individuals into the behaviours and characteristics expected for a member of their profession, enables them to achieve the standards of practice required to achieve professional regulation (Day 2006, Morison, Johnston and Stevenson 2010) as well as adopting the identity of that particular profession as reported in the findings of Stull and Blue (2016).

Similar findings to that of Stull and Blue had previously emerged from Howell's (2009) grounded theory study of occupational therapy students in America. Both sets of authors highlighted that some students may enter the education system with preconceived stereotypes of other professions already evident. These stereotypes were broken down as students became more confident in their own and other's abilities indicating that stereotypes are therefore perceived not to be fixed but to vary dependent upon the context (Hornsey 2008).

Whilst Stull and Blue's findings conclude that IPE leads to a weakened professional identity, this contrasted with the findings of Howell's study whereby the OT students enhanced theirs during their interprofessional learning process.

Both of these studies took place in academic settings; however, it is proposed that practice based socialisation can also lead to the development of a climate of "trust, reciprocity and respect" between colleagues which can promote engagement and integration (Centre for Workforce Intelligence 2013, p. 11) and enable the breakdown, over time, of historical boundaries. This also reinforces consistency of approaches between the members as a result of functioning within defined categorisations.

Within the study within this thesis, the practitioners with a greater amount of work/life experience presented as more confident in themselves and therefore more accepting of greater integrated working. This concurs with one of the findings from Hutchings, Scammell and Quinney (2013) whereby some students were able to work collaboratively with others prior to the formation of their own professional identity.

Whilst taking this into consideration, Khalili et al (2013) identified a gap in research to explore the processes that must be undertaken for individuals to develop a dual identity that is, the identity of their professions and that of their in-group. Due to the number of social groups that the participants were members of, it may be argued that the use of the term "dual" is somewhat minimalistic and that instead the participants actually held a multitude of identities which varied dependent upon the situation.

The services within this study build upon this, demonstrating a proactive stance to collaborative practice, and encouraging staff to recognise the value of working jointly with their colleagues, respecting their values and beliefs in the process (WHO 2010). The development of the group identities of these practitioners was therefore perceived to be enhanced through their socialisation into the culture of their different social groups.

There was the expectation, as part of this socialisation, that individuals would adopt the expected behaviours, rules, beliefs and habits (Wackerhausen 2009) of each group's culture so that social order and stability is maintained. This allowed for continuation of already, usually, evidenced and customary approaches to practice.

From the responses of the participants, what became evident was that gradually these approaches to practice had become habitual so that individuals subconsciously continued to meet the cultural requirements of their social groups without having to consciously consider their responses.

Through the process of socialisation, the group members had developed shared frames of reference, whereby uniform meanings are applied to phenomena. This had created a sense of continuity as these meanings are perceived in similar ways by the individuals within the team. This conformity also offered assurance of consistency of practice and decision making, reinforcing Farrell et al's (2001) findings that as teams develop, the behaviour of the members become more integrated, due to a decrease in variance in interpersonal behaviours.

Hudson (2002, p. 16) concurs with this optimistic hypothesis, subsequently highlighting that "members of one profession may have more in common with members of a different profession than with members of their own" through socialisation to a work group which overcomes that of socialisation to a profession.

That these authors had already identified this was pertinent to this study as the participants reported there was no evidence of a written mission statement or vision for each group, or written criteria for how they were expected to behave. Instead, there was the suggestion that there was an implicit "code of conduct" in relation to the expected behaviours of group members. As all participants reported that they had not received an induction upon starting in their posts, these values and behaviours were reported to be learnt through the process of observing others, and receiving support and supervision from colleagues who guided their socialisation into their respective group cultures.

From the perspective of a collective, Hall (2005, p. 188) defined the term culture as "the social heritage of a community", recognising that each social group has unique differences to others even though the type of work may be the same. Hall described culture as incorporating values, beliefs, attitudes, customs and behaviours that are reinforced through professional socialisation and impact on how professions interact with each other.

Unless these are challenged, Hudson (2002) suggests that new members adopt a similar approach to those inducting them, thereby perpetuating behaviours and institutionalising these to the extent that they become second nature and assimilated as “fact”. Based on the findings from this study, this was the process undertaken as participants reported recognising, and eventually embracing, the knowledge, skills and competencies demonstrated by those with whom they worked.

It has already been suggested that at any one time each participant may be a member of a variety of social groups, with each group serving their own purpose and working towards different outcomes. The success of each relies on a consistency of approach between those participating in them in order to manage expectations, professional boundaries, status and identity issues.

To contribute to this Wackerhausen (2009, p. 467) identified a need for practitioners to increase their awareness of “concepts, theories, ideas and knowledge” which were external to their own profession and which would enhance their professional identity. In doing so it may also be suggested that this would also enhance an individual’s own self-perception.

6d.3.2 Constructing identities

Stets and Burke (2000) suggest that in society an individual’s self-concept comprises a combination of social categories developed during the course of their life. In contrast, within the extant literature, a professional identity may be considered to be more restrictive, associated with “enacting a professional role” (Chreim, Williams and Hinings 2007, p. 1515). A professional identity provides a definition of the characteristics associated with that role, with King and Ross (2004) advocating flexibility, suggesting that it is constructed through the process of interacting with others, and reconstructed subjectively each time the “interpretation, action and interaction” takes place (Chreim, Williams and Hinings 2007, p.

1528). This reinforces the dynamic nature of how this role may be interpreted, but within the parameters expected for each social group.

From the findings of the study within this thesis, it is proposed that individuals have a core identity, but that this is malleable and alters dependent upon the role of the different social groups of which they are members. Whilst the core characteristics for that individual stay the same, these are enhanced based on the different expectations of them.

Within SCT, Turner et al suggested the self-concept comprises three levels of self-categorisation; human identity, social identity and personal identity (Hornsey 2008). Categorisation into the in-group contributes to the development of these for members of that social group as members define their self in relation to others in the group and those outside of it (Hean and Dickinson 2005). This therefore indicates the presence of commonalities, and potentially positive attitudes, between those in that group and, in contrast, differentiation, or more negative attitudes with others (Burford 2012) external to it.

Within the Social Identity Approach this can lead to favouritism of those within the group and discrimination of the out-group. An effect of this is that recognition of the negative aspects of others can be perceived to enhance the self-image and self-concept of the in-group as participants define themselves in relation to this, adopt the identity of it and then compare the in-group with other groups.

Indicative of this, within this study, is the relationship between the intermediate care team staff, their managers and ward based staff. Whilst the former articulated, and valued, the support offered to each other and the appreciation of their knowledge and skills, the latter two were not considered as favourably by the participants. Instead they could be considered to be out-group members with feelings of mistrust and dislike aimed towards them and evident from the intermediate care operational staff.

Tajfel and Turner (1986) identify that in such instances the members of the in-group are more likely to behave towards the out-group in the way expected as a collective, as opposed to their individual characteristics. People will therefore act in accordance with the way expected of them by their group as opposed to how they would normally act in an individual situation. Supporting this perspective there were similarities in how participants articulated their feelings about, in particular, strategic managers and ward based staff.

Whilst this may be perceived as learning that is socially constructed within the context of their team, moulding others, (McPherson et al 2001, Cribb and Gerwitz, 2015), Stull and Blue (2016) propose that this development is not a linear process but one that fluctuates as practitioners construct their professional identity or alternatively perceive it to be challenged.

Within the study in this thesis, participants defined themselves in relation to their service, and they became defined by others in this way (Tajfel and Turner, 1986) reinforcing the strength of their collective identity. Threats to the whole group were perceived to be threats to the individual themselves, reinforcing that through this process, individuals can become psychologically attached to, and gain a strong identity from their occupational roles (Barrett and Keeping 2005), rather than their professions.

Within the literature frequent references, which attributed the failure of interprofessional collaboration to conflict, based on differences in professional identities, have been made by numerous commentators (Wilson and Pirrie 2000, Elston and Holloway 2001, Freeth 2001, Hudson 2002, Irvine et al 2002, Baxter and Brumfitt 2008, Petri 2010, Hall 2005, Cameron 2011, McNeil, Mitchell and Parker 2014).

However, rather than supporting the concept of interpersonal conflict, participants in this study instead demonstrated a flexible identity, behaving in a way expected by a member of their profession but also

within a way expected of a member of their respective social groups. This was noted within the Social Categorization Theory approach which reinforced identities may co-exist (Hean and Dickinson 2005, Burford 2012), taking it in turns to come to the forefront dependent upon the situation faced.

Khalili et al (2013) proposed the recognition of a dual identity suggesting this would assist in creating a new generation of health care professionals who were able to successfully undertake integrated collaborative practice through completing an iterative three stage process of breaking down professional barriers, interprofessional role learning and dual identity development (Khalili et al 2013).

Reading their article after the completion of the interviews, data collection and analysis, it was this three stage process that resonated with the findings from this study as a useful description of the process informally undertaken by the participants to contribute to the development of collaborative practice and their multiple, as opposed to dual identities. This may also be considered comparable with the three stage process of the Social Identity Approach of internalising group membership, identifying a group and allowing for social comparison (Trepte 2006).

Due to a number of social groups in which they participate, and subsequent identities, it may be argued that not all of these identities may be stable at the same time. As a result of changes to professional roles and boundaries this can result in a sense of ambiguity amongst those affected (King and Ross 2004).

The findings from this study concur noting that, for a period of time, participants highlighted unclear role boundaries leading to confusion and concern, until these were resolved through socialisation in conjunction with others. Eventually, participants had harmonised their behaviour with that accepted as relevant within the group in order to confirm their position as a group member. The psychological impact of this was to

substantiate their acceptance within their respective collectives as they adopted the expected norms, values and behaviours of the group.

This concurs with a study by Funnell (1995) in which immature professional identities of students were threatened by overlapping professional roles and responsibilities resulting in an inflexibility in participating in interprofessional collaboration. Within my study these feelings were reported as temporary ones as participants who reported feeling this way developed a greater understanding of theirs and others' roles within the contextual setting in which they worked, through the process of socialisation.

This reinforced the concept of learning from others, with Lave and Wenger (1991, p. 115) highlighting a strong relationship between learning and identity. They suggested that these were "aspects of the same phenomenon" that was constantly in motion, working reciprocally between individuals and processes to manage activities, events and facilitate change.

This illustrated the concept of *Dynamic Consistency* as, even with a change of personnel and upheaval, consistency was sought and retained in terms of order and meanings.

The formation of a social group requires this negotiation of meaning as participants engage with each other to develop their own and also collective identities. Wenger (2008, p. 151) proposed that "an identity, then, is a layering of events of participation and reification by which our experiences and its social interpretation inform each other". This is continuously negotiated during the course of our everyday experiences and dependent on the social and historical context, thereby resonating with the findings from the study within this thesis.

Whilst individuals are negotiating and reconstructing their identities they need to ensure some continuity of practice, recognising the history of

what has gone before; determining what part of this should become part of their own identities. Wenger (2008, p. 158) describes this as “the past, the present and the future” ... “embodied in interlocked trajectories” which interact to contribute to the creation of individual and collective identities.

Reinforcing this, within this study, the participants recognised that they brought prior experiences and learning with them as they joined new groups. They were, however, open to taking on new ways of working through flexible practices.

A practitioner’s professional identity is therefore not a rigid entity but may be constructed and reconstructed based on situation and context. A downside of this, however, has been that without open and transparent lines of communication, it is sometimes not possible to determine where the boundaries of some roles start and stop (D’Amour et al 2005).

Through the support of others, participants within my study had accepted sharing competencies which helped them to feel less threatened by the redesign of roles and the sharing of tasks and skills. To assist this, Day (2006), commented that teams need to be clear about what competencies to share and when these could be used, with clarity of approaches and boundaries offering reassurance to those within the service due to the overlap of tasks undertaken.

A formal competency framework had been devised by the services within this study to determine what were core skills and those that were generic. This enabled participants to undertake interventions and collaborate with an awareness of the purpose and direction of the group, thereby ensuring consistency in practice.

6d.4 Promoting consistency in collaboration

Teams are described as synergistic (Webster 2002) when the members work together successfully with equitability of input and status from all members who are engaged with the decision-making process.

Within health and social care rhetoric, there is the political view that interprofessional practice is essential for the delivery of high performing health and social care, requiring the sharing of exclusive knowledge and breaking down of divisions of labour between professions.

Whilst legislation, pertaining to this, advocates practitioners working across traditional professional boundaries it has also been recognised that they were expected to do so, often, with limited guidance or development support (Robinson and Cottrell 2005), particularly in relation to understanding the diversity of the different professional paradigms. Petri (2010) suggested that there was a need for support from an organisation to enable the success of interprofessional collaboration. However, this was not forthcoming from any of the organisations in this study.

In order for interprofessional collaboration to be effective, there therefore needs to be a clarification, or harmonisation, of the remit of the service and the participant's role within it to ensure a consistent approach by members.

This was supported by Pedler et al (2004) who suggested that a script for developing this should involve clarifying the remit of the service and member's roles. This would establish what a service can expect from an individual undertaking that role, but also how the different roles fit together, or overlap (Petri 2010), in order to contribute to the episode of care required by each service user. However, these processes take time to develop and there needs to be recognition that they vary depending upon each contextual setting.

Towards the later stages of group development, uniformity emerges when individuals assimilate a collective identity (Stets and Burke (2000), through which the commonalities between members, as identified above, are recognised.

Similar to Nancarrow's study (2004), within the services in this study, horizontal substitution took place, with practitioners working outside the traditional remit of their own profession to take on the competencies of other professions.

Through the process of working with colleagues the participants had increased their understanding of different practices, processes, skills and had adapted their values, beliefs and assumptions. The nature of interacting with others in a contextualised setting had shaped not only the individual paradigms but also, the collective prototypes of the team, increasing their awareness of knowledge, skills and paradigms outside of their own profession.

This is described by Frost (2005) as a dynamic process of interaction as individuals define, re-define and negotiate how to work together. It also contrasted with the findings from Johannessen and Steihang's study (2013) of professional roles within an intermediate care unit. Instead, their results indicated more of a uni-disciplinary approach than the integration within the study in this thesis.

By having an understanding of their own role and that of others this enabled the participants, in the study within this thesis, to appreciate their responsibilities and function, when participating in an episode of care and compare these with their colleagues. There was recognition of areas where professional boundaries have become permeable and there was the opportunity for practitioners to provide interventions based on shared skills to enhance consistency of approaches.

6d.5 Unconscious collaboration

The services in this study shared established, and agreed, policies and processes, assigning, as a group, the norms and behaviours expected to be exhibited to concur with these. Hewitt, Sims and Harris (2015) described these as a code of conduct for the social groups. It could be argued that these were akin to those of the individual profession's own

codes in that, similar to these, they provided an element of regulation in terms of the behaviours expected by each group's members, also having a negative effect on those who do not comply with them.

It has already been noted that through the process of socialisation participants adopted the norms, values and beliefs of their respective social groups to such an extent that these, in effect, became tacit, with the practitioners collaborating in an interprofessional way at a sub conscious level. They reported doing so without realising, as it was a form of working that had become habitual. These ways of working had become the mental models for the team with the participants considering that, as a result, interprofessional collaboration didn't take much effort to undertake.

This reinforces Wackerhausen's (2009, p. 462) comment that when things become habitual they become so "natural" to undertake that they take place without us realising they are happening, in effect functioning at an unconscious level.

Unconscious collaboration became a theme reinforced from the findings of this study, as during the semi-structured interviews, what became clear was that participants who had been undertaking the job for a number of years were the ones who initially found it most difficult to explain how they collaborated with others. Practices and processes had become so ingrained that they had become part of the individual and collective memories.

That this had taken place ensured the maintenance of behavioural standards and practice norms, contributing to the continuity and consistency of collaborative practice within the services in this study.

6d.6 Summary

From the findings of this study participants had developed a strong collective identity, considering themselves to be part of "an identifiable

unit" (Buchanan and Huczynski 2010, p. 300), developing common meanings for phenomena through the processes of interaction and consensus. Through socialisation into their respective social groups, individuals learnt the values and expected behaviours of these, conforming due to a desire for order and meaning in their lives.

Within the services under study there was the evidence that this was the case as a means of promoting cohesion and consistency, with high levels of emotional and professional support and relatively low levels of friction between colleagues reported.

The development of collaboration through "**Facilitating Interaction**" between professionals can therefore be described as a dynamic, social process. This is facilitated by interaction between participants, with altruistic behaviour a key element as participants demonstrated a recognition of the need to behave in a way that benefitted the service and those working within it.

In addition, the creation of a collective and individual identity is therefore a socially constructed concept, defining the position of the individual and the social group, whilst also maintaining consistency of practice to ensure integrated working.

This sub-chapter completes the discussion of the findings from this study. In addition, the literature, processes and findings of the study have so far been explored within this thesis. Bringing the thesis to a close, the following chapter will now conclude the study and make recommendations for practice and for further study.

Chapter 7 – Research conclusion, recommendations and limitations

Introduction

The previous chapters have explained the rationale for the study, the choice of methodology, the data collection and analytical processes undertaken and subsequently the findings leading to the development of theory.

A Constructivist Grounded theory approach was utilised to explore the subjective experiences of participants working in intermediate care, seeking an understanding of how they perceived interprofessional collaboration within their own services.

This chapter now will bring the thesis to a close by summarising the outcomes of the study, and the implications of these for practice, but also opportunities for further study. In doing so it will apply Charmaz's quality criteria (2014) to assess the governance of the study and any limitations which may have affected the results of this.

First though a brief reminder of the original research questions that set out the parameters for the study.

7.1 Revisiting the research questions

In chapter one the research questions were identified as:

1. What are the factors contributing to the development of interprofessional collaboration in intermediate care teams?
2. How does interprofessional collaboration in intermediate care teams present?
3. How do teams maintain interprofessional practices?

3.1 What factors can occur that can de-stabilise intermediate care teams?

This thesis has highlighted the processes undertaken, but also the findings obtained to answer these questions. Semi-structured interviews with participants working within intermediate care settings and the process of simultaneously collecting and analysing data to abstract findings, has led to the generation of a core category and theory.

In chapter five the basic social process of "**Facilitating Interaction**" was identified. In conjunction with the recognition of the presence of Dynamic Consistency, this chapter offered an explanation of how the participants within the study developed interprofessional collaboration within their services and subsequently how this was maintained.

These social processes led to the creation of alliances against, what the participants perceived to be, greater threats from outside of their in-groups, contrasting with the potential for intragroup role boundary conflict that previous empirical studies had reported.

The theory that subsequently emerged and the extrapolation of the 4Cs of Interprofessional Collaboration may therefore be utilised to recognise that individuals create and sustain interprofessional collaboration through negotiated interactions to achieve consensus. Participants identified putting coping strategies in place to maintain this, managing perceived stressors at both interpersonal and collective levels.

Destabilising factors within services predominantly related to decisions made about the design of them, usually by those in strategic or commissioning positions. These were reported as temporary situations that were discussed within the affected groups and appropriate action undertaken to regain a state of consistency once again.

Whilst adversity may be construed, in some studies, as a potential destabilising feature, this did not prove to be the case in this study.

Instead it emerged as an influence in the development of interprofessional collaboration. In addition, situated learning was also a factor contributing to this. Participants reported undertaking interventions as generic practitioners, sharing the competencies and knowledge that were traditionally considered to be the remit of other professions.

This involved the participants embracing the diversity of their colleagues, accepting the differences between themselves and others and maintaining open lines of communication to develop permeable boundaries between professions as an outcome of this learning. In doing so they questioned the role of formal IPE in preparing them to collaborate.

Within a Social Identity Approach the actions of the individuals within a social group are deemed to be based on the accepted values, beliefs and behaviours which determine its culture. The sharing of these, within this study, enhanced the interpersonal relationships between the group members, building trust and mutual respect, whilst empowering the individual to work autonomously within the contextual setting due to an increased awareness of the behaviours and practices expected of them.

Consideration of whether the findings are transferable is documented in section 7.4.

Based on the information above, and that included within the rest of the content of this thesis, it is therefore contended that the research questions within this study have been answered through the discovery of social processes that contribute to creating and sustaining interprofessional collaboration, but also to the theory that emerged from the data.

7.2 Criteria for assessing the study

Qualitative research has long faced criticism, by those advocating for quantitative approaches, as being too subjective and difficult to replicate (Bryman 2012).

I note Charmaz's comments that evaluative criteria for research depends upon "who forms them and what purposes he or she invokes" (Charmaz 2014, p. 337). A Constructivist approach has been maintained throughout this study with the flexibility of the chosen methodology of Constructivist Grounded Theory the tool for data collection and analysis. A decision was made, therefore, to adopt the criteria advocated by Charmaz (2014), as guidance, to maintain continuity.

She suggested the criteria credibility, originality, resonance and usefulness to account for the construction of the theory and how this contributes to existing knowledge. These criteria are a combination of Lincoln and Guba's (1985) framework of credibility, dependability, confirmability and transferability, devised to demonstrate the trustworthiness of qualitative inquiry, but also incorporating elements of Glaser's (1978) standards of fit, work, relevance and modifiability too. Charmaz considered Glaser's criteria useful when reviewing the analysis of the data, identifying (Charmaz 2005) that, based on them, the theory must fit the empirical world and provide a workable understanding and explanation of it, whilst being flexible enough to be refined over time as required.

To enable the reader to evaluate the quality of the processes and analysis undertaken within this study, each of Charmaz's criteria are considered in more detail in Appendix 13. A condensed summary of this information is provided in the following sections.

The study, reported within this thesis, was a retrospective one, exploring the events of the past from the subjective perception of an individual. It is therefore appreciated there is a risk that the participants' verbalisation of these may not reflect exactly how the events occurred. This was deemed an acceptable situation as it is difficult to verify an individual's interpretation of their thoughts and feelings (Denscombe 2008, p. 200).

Denscombe instead suggests a need to “gauge credibility” of the information shared and this will be reviewed in the following section.

7.2.1 Credibility of the study

Polit and Beck (2010, p. 106) define the credibility of a study as where there is confidence in the data and the “researcher’s interpretation of (and inferences from) the data”, requiring sufficient evidence to be provided to explain the findings.

This study has explored the experiences of clinical staff working within intermediate care settings, placing an emphasis on how interprofessional collaboration is created and sustained. By undertaking interviews with them and subsequently analysing the data, this contributed to increased familiarity and insight into their experiences and the social processes used within each service. For clarification, the research methods and processes utilised were documented in Chapter four and extracts of verbatim text, along with explanations of how these were coded, and the data conceptualised were provided in Chapter five.

To obtain a diverse range of experiences participants from five different services and three different professions contributed to the study. Data collection ceased once theoretical sufficiency was achieved whereby no new concepts were identifiable from the data.

7.2.2 Originality of the study

In this section the originality in research will be highlighted demonstrating that it is the product of individual work and ideas and produces an original contribution to knowledge.

This study adds to the body of work already available within the interprofessional field. Although the discussion chapters have indicated some similarities with the findings of extant studies, the categories generated from the data, along with the abstraction of the *4Cs of Interprofessional Collaboration* and *Dynamic Consistency* are original to

this study and reinforce the presence of multiple realities perceived by the participants. The introduction of the Team Circles tool was a significant factor in highlighting this due to no two participants considering the composition of their services in the same way.

The findings emphasised the impact that stressors within the working environment play on forming and maintaining interprofessional collaboration and the theory generated from the data offers greater insight into how the participants responded to the demands they faced in their occupational roles.

In addition, the findings from the study challenge perceptions of pessimistic approaches to interprofessional collaboration, the role of the commissioners in the development of services, but also the extent to which formal IPE accurately prepares students for their need to closely collaborate with other professions once they begin their clinical careers.

7.2.3 Resonance of the study

The resonance of the study concerns itself with whether the findings reflect the lived experiences of the participants and whether they make sense to them.

Upon sharing the findings with some participants, the notion of maintaining order and structure through *Dynamic Consistency* and **“Facilitating Interaction”** resonated with them. As, for many of the participants, interprofessional collaboration had become a habitual way of working they suggested that the conceptualisation offered them insight into the fact that it could not be considered a static entity but was a state of flux that was adapted dependent upon the situations the participants faced. It therefore offered them a representation of their perceived realities.

7.2.4 Usefulness of the study

When undertaking the study, the value that it would bring to the field of interprofessional practice was a consideration. This study offers a theoretical interpretation that may be used in a variety of contextual settings to rationalise behaviours of those working collaboratively across traditional professional boundaries. But it may also be used to provide insight into how the experiences of individuals working collaboratively within an intermediate care setting may be improved.

Opportunities exist for further research, which are documented in section 7.5 and a greater recognition of the alliances created between professionals which contributed to the development of collective identities and enhanced intragroup relations.

The following section will highlight the contribution that the study may be perceived to make to extant knowledge.

7.3 Contribution to extant knowledge

Previous empirical studies have suggested that interprofessional teams may experience many issues affecting interprofessional collaboration including “boundary frictions, hierarchical imbalances and power/status inequalities” (Reeves, MacMillan and Van Soeren 2010, p. 259). None of these issues were evident as significant or permanent within the services under study. Instead the participants reported that there was a high degree of role overlap, equity, support, respect, trust and empathy between themselves and their colleagues.

The results of this study have provided an increased understanding of the attributes and antecedents required to facilitate interprofessional collaboration, recognising that knowledge is conveyed between the participants through the process of shared learning.

Emphasis was placed by the participants on the maintenance of consistency and order and it was through mutual engagement between

participants that relationships were shown to be developed, understandings negotiated and processes put in place for action. Shared learning therefore took place to ensure continuation of consistency in practice and learning how to be part of a collaborative collective based on the tacit and implicit norms, values and behaviours learnt through socialisation.

Based on the findings from this study I have summarised these areas of new knowledge below.

1. Through "**Facilitating Interaction**" social processes developed which enabled participants to maintain order and structure, even in times of significant change and adversity. The 4Cs of Interprofessional Collaboration, whereby participants put coping strategies in place to operate flexibly within agreed parameters of behaviours, norms and values for their service, offered a sense of stability during periods of upheaval.

There was a mutual understanding of their own and other's roles, and shared competencies and responsibility with colleagues for providing clinical interventions for those on their service. This promoted continuity of care and also consistency of practice whilst also encouraging order and the management of disharmony.

2. The development of the "Team Circle" tool and the subsequent analysis of this highlighted the presence of multiple realities. The "Team Circle" diagram therefore demonstrated itself as a data collection tool that could be used to explore similar information from any other contextual setting, whether health related or not. It forms an individual construction of individual's social groups and others with whom they network.

3. Research into intermediate care has previously predominantly concentrated on quantitative outcomes of intervention, for example length of stay. Taking its lead from studies such as

Nancarrow (2004, 2007, 2013), this study has provided an opportunity to explore the development of interpersonal relationships between the staff members on an individual basis and highlighted the different perceptions that each brings to these. The findings from these may be used as a baseline for others to explore further.

4. Whilst change is inevitable in any modern day health service, participants suggested that change is now the status quo. It is suggested that it is a constant variable that participants perceived as a stressor and therefore needed to manage. In contrast, it was reported that periods of stability were rare.

From a strategic and commissioning perspective service redesign was suggested and reportedly put into action even before the changes previously suggested had been fully operationalised. This therefore created adversity for the participants as they were expected to manage such a situation, introduce new ways of working and maintain operational standards whilst doing so. It is therefore recommended that as part of the commissioning evaluation process, recognition of how decisions will be operationalised needs to be considered in more detail.

5. Operational staff recognised and valued working in a collaborative way with colleagues from different professions and teams. Within this study the participants considered that there were greater threats from others who were deemed to be outside of their social group, than threats to their professional integrity, or potential for intragroup role conflict that had been suggested by previous empirical studies.

An optimistic approach to collaborative practice was therefore perceived as being important to maintain the wellbeing of the practitioners as it offered them a sense of self-worth to be part of a social group, but also reassurance in terms of practice standards

and interventions.

6. Key to interprofessional collaborative practice is the expectation that professionals are willing to adapt their practice to incorporate other profession's skills and knowledge. Professionally socialised boundaries have traditionally been strong across health care professions and it was reported to have taken time and a great deal of effort to re-negotiate these within the context of the services under study. All participants reported, however, that the effort has been worth it.

When participants become more aligned with each other and demonstrate an increased flexibility of roles, responsibilities, skills and competencies, it provided the opportunity for colleagues to complement each other's skills through gaining insight into what they could achieve as a whole rather than working on an individual basis and duplicating resources and effort (Senge 2006).

7. A recurring theme, within this study, was that the participants reported that they did not consciously think about collaborating with their colleagues. Collaboration had become assimilated as a habitual way of working; hence the descriptor unconscious collaboration was applied to it. This reinforced the extent of allegiances and cohesion reported by the participants.

8. An additional major strength of the interactions reported between participants related to the emotional and psychological support they suggested was displayed between them. Frequent responses during the interviews related to the participants caring for each other, with trust, understanding and mutual support evident across traditional professional boundaries.

Whilst the participants recognised their role in supporting service users, they considered that they also had a duty to support each other, irrespective of profession. Through interpreting the

responses they provided, they genuinely appeared to care for each other, combining collectively against the chasm they perceived was created between them, the strategic managers and commissioners, whilst managing high demands, limited resources and frequent service re-design.

The interpersonal dynamics therefore were deemed to be stronger than the interprofessional ones and demonstrated that irrespective of the profession of an individual, it is their individual interactions that contribute to the success of these relationships.

Table 5 – Contribution to extant knowledge

This study has demonstrated that in spite of professional identity differences, it is possible to traverse traditional professional boundaries and develop an interprofessional culture. It requires the good will of the staff to do so, a shared vision, support from the organisation, the development of mutually agreed protocols and practices and transparent lines of communication.

Based on the above factors, the commitment to collaborative practice was clearly evident from the participants interviewed for this study.

7.4 Transferability of the findings

It is appreciated that any study is going to be evaluated by those taking the time to read it. However, a criticism faced by qualitative researchers, according to Horsburgh (2002), is that the qualitative approach lacks scientific rigour, thereby questioning the integrity of the findings. Within quantitative research the act of generalization, of making inferences as to whether the findings can be extended, by the researcher, to other settings, is considered to be "a key quality criterion" (Polit and Beck 2010, p. 1451). In contrast, this is considered to be somewhat contentious to use within qualitative research, due to the different ontological and epistemological assumptions within this compared to a positivist approach. Emphasis is instead placed on multiple realities, on achieving a

richer understanding of the phenomenon and on recognising the subjective nature of the findings; no absolute truth. The findings from qualitative studies are therefore not generalizable and alternative trustworthiness criteria are indicated for use to evaluate these types of studies.

The criteria used to evaluate the study within this thesis has already been documented in section 7.2, however within this section greater consideration will be given to the usefulness and transferability of the findings to alternative settings. Bitsch (2005) described transferability, as an alternative to external validity and generalizability for use within qualitative studies. It provides the reader with information to help THEM, rather than the researcher, to establish whether the study's findings would be applicable for use in other settings and with other populations Denscombe (2007) and Polit and Beck (2010).

To enable the reader to determine this, a thick, descriptive account of the original study is required (Lincoln and Guba 1985 and Polit and Beck 2010). This was defined by Polit and Beck (2010, p. 1453) as "thorough descriptive information about the research setting, study participants and observed transactions and processes". In effect, and similar to the Constructivist Grounded Theory methodology, this requires a co-constructed relationship between the researcher as provider of information, and reader as receiver of it.

The study documented within this thesis has undertaken exploratory, qualitative research into the experiences of individuals working collaboratively within intermediate care settings. This type of service is not unique to the geographic location of the study, but is considered to be a mainstream service that is provided nationally. This therefore offers opportunity for comparisons to be made between the findings of the services in the area studied and those elsewhere.

In order to increase transparency for the reader, and due to the extent of my participation in the research processes, I have documented these within the previous chapters of this thesis. Chapter four has provided information about the data collection and analytical processes undertaken, the demography of the participants and also background and current information about the contextual settings.

Chapter five provided a detailed description of the findings which were obtained, based on interpretations of how the researcher has perceived the data, working in partnership with the participants to co-construct these interpretations. These co-constructions were generated through interactions with the participants at specific points in time, and through subsequent analysis of the data obtained. Due to my personal belief in subjective and multiple realities I would assert that another researcher is therefore unlikely to arrive at the same theoretical explanation even if following the same methodology and processes.

Whilst it can be argued that it is not possible to reproduce social situations and conditions that match exactly those faced by the participants in this study, and recognising, based on the content of the transcripts, that no two interviews were constructed in the same way, there is recognition of the opportunity for similarity in some aspects (Corbin and Strauss 1990). This was indicated between the services and participants in my study through the process of constant comparison of the data which identified resemblances in the responses of those taking part leading to the development of the *4Cs of Interprofessional Collaboration* and the Grounded Theory.

Glaser (1992) highlights that Grounded Theory is fluid and modifiable as new data emerges. Through the process of data collection and analysis, with this study, concepts and categories were developed. Glaser (2002) described concepts as a pattern in the data that emerges through constant comparison, relating “seemingly disparate units to each other by

an underlying process” (Glaser 2002, p. 26). Concepts were repeatedly present in the data and therefore offer some assurance of the possibility of transferability as they were tested out with additional participants in the same, or alternative services, through the process of theoretical sampling.

Corbin and Strauss (1990, p. 15) suggested “the more abstract the concepts... the wider the theory’s applicability”, hence the deliberate decision, when constructing the conceptual framework and the theory, that it was not written in a way that was context specific. The theory produced represents my interpretation of the reality that was reported by the participants, although assurance in this was offered by some participants as they confirmed that this reflected their understanding of their situations also. Whilst addressing the realities faced by the participants, within this study, this also offers the potential scope for it to be considered for review within other contextual settings.

In addition, although each clinical setting, within the study, was unique they did share some structural and personnel similarities, particularly in relation to the perceived stressors faced by the participants in all of the different services. A pattern was identified based on the social processes used to manage these, which offered a broad indicator of the opportunity for transferability between them, which readers may use to compare with their own experiences. The findings subsequently identified the strength of interpersonal interactions that took place, with participants developing coping strategies to manage the stressors they faced, working together to negotiate consensus and consistency in approaches.

Whilst not in a position to suggest that the findings of this study are able to be transferred to alternative settings, it may be concluded that sufficient information has been provided, within the text of this thesis, to enable others to consider the possibility of doing so.

7.5 Recommendations

This study has highlighted gaps in knowledge which have indicated opportunities for further study. In this section recommendations for further study and exploration of practice will be considered, based upon my interpretation of the data obtained and the meanings and actions applied by the participants.

7.5.1 Recommendations for further study

1. Webber (2016) suggested that if individuals felt unsupported in their role they either left a service or were unmotivated and unhappy. Within the context of this study participants demonstrated emotional resilience, reporting that they considered themselves to be supported by their peers and immediate line managers, but less so by their strategic managers and the commissioners of their services. Ironically, the findings suggest that the pressures placed on the participants by the commissioners and strategic managers indirectly enhanced interprofessional collaboration as participants worked collectively to respond to these. However, the general unhappiness with those in positions of strategic power was a recurring theme across all the services and therefore provides an opportunity for further exploration in future studies, as to whether this is unique to intermediate care settings or is replicated in other services or organisations.
2. Whilst participants stated that they enjoyed working with their colleagues and providing intervention for their clients, they reported suffering from change fatigue and feeling demoralised with the constant change that was prevalent in their services. Participants highlighted that they were not provided with accurate information in a timely manner in relation to proposed changes affecting their services.

There is therefore the opportunity to explore further the physical and psychological impact of frequent and uninformed change on those who are required to operationalise decisions made at a commissioning level.

3. As highlighted in recommendation number 1, an unexpected outcome from this study was the recognition of the role of internal and external stressors in contributing to establishing interprofessional collaboration within the services in this study. Rather than creating divisions between colleagues, the stressors assisted in the development of cohesion as participants communicated to develop coping strategies to manage these. This outcome warrants further exploration to determine whether this situation was unique to the contextual settings under study or whether they may be replicated elsewhere.
4. Intermediate care is not unique as the only setting that interprofessional collaboration takes place in, therefore other health and social care areas will provide additional contextual settings within which to seek further insight into the generation of interpersonal relationships in interprofessional collaboration through future studies.
5. In addition, further exploration specifically into the role of **"Facilitating Interaction"** leading to the development of Dynamic Consistency and the 4Cs of Interprofessional Collaboration within services is required to ascertain whether others follow this process and whether the findings are transferable.
6. Political rhetoric relating to interprofessional collaboration suggested its value in improving the patient experience and the quality of interventions that they received. Whilst this was not the remit of this study, further studies into the experience of patients could be undertaken to try and identify what impact, if any, interprofessional collaboration has on the interventions they receive.

7.5.2 Recommendations for the field of practice

1. There was no obvious and significant disharmony amongst the participants and their immediate colleagues in this study, however, there was recognition of the need to be professionally mature and secure in their own role to participate in interprofessional collaboration. This assisted the participants to be able to resolve any issues that arose from interactions, but also realistically it is in the best interests of the operational managers that their staff have high levels of relational co-ordination to contribute to achieving performance indicators and increased cohesion. Individuals working in interprofessional groups should therefore be offered encouragement, by their managers, to interact on an interpersonal level as well as a professional one, to develop closer working relationships and attain a greater awareness and understanding of each other's roles and responsibilities.
2. Many participants identified a lack of time to undertake an induction or manage the impact on interpersonal relationships when changes took place. The findings, within this study, suggested that operational managers assisted with this, once services were operational, by supporting opportunities for situated learning, at both formal and informal levels, putting structures in place to reinforce the participants' approaches to work across traditional professional boundaries, sharing knowledge, skills, and values. Through ***Learning whilst doing*** this enabled the participants to develop the practices and processes required for working in that setting and influence each other whilst doing so.

However, many participants considered this to have taken place too late and a recommendation from these participants would be that sufficient time was provided for individuals to manage change within the services and to develop a shared understanding of their occupational roles at the point that change was planned or had

newly occurred. This was particularly pertinent due to the frequency of change identified by them.

It was evidenced that where services had been re-designed, or new services formed, on all occasions there was insufficient development time allowed before they were expected to be operational. Formal organisational structures could assist in supporting this, however, the findings suggest that, whilst this is recognised at an operational level, this would require change at local, strategic levels, including changes in commissioning, to factor in opportunities for learning during times of change. Commissioners are therefore advised of the need to allow for induction and development time when re-designing services. However realistically, due to the demands on the performance of services, and the continued need to provide high quality, patient centred care, it is questionable whether time would be allowed by them to support this.

3. Comments from junior grade staff in the study challenge the existing undergraduate curriculum design that they experienced, and question how well prepared they actually were for working collaboratively straight from university. Participants instead suggested that, in contrast to academic learning in a formal environment, learning within the clinical setting offered more value. It is therefore suggested that curricula should be developed so that, from an early stage in their undergraduate education, students are encouraged and enabled, to recognise the extent of role, knowledge, and competency overlap between their profession and those of others, with the potential that this may have for their own professional development.

To implement this will require logistical and institutional changes as academic curriculum designers continue to review how they provide undergraduate learning, taking into consideration the increased emphasis, by the participants, of learning in the clinical setting.

However, as well as impacting on academic institutions, this is also likely to require a greater recognition by the different professional bodies to review their accreditation criteria for acceptance into the professions.

The implications of these changes are that in doing so this would adapt existing academic practices, but would also contribute to the demands of future health and social care services in terms of workforce development.

7.6 Limitations of the study

When reflecting on this study it was necessary to not only consider what had gone well, but also areas where actions could have differed. This section will now consider limitations that may have impacted on the outcome of the study.

1. Corben (1999) reported that researchers should be honest about the limitations of their studies particularly in relation to the risk of bias. This was a concept that I was particularly aware of due to my past experience of working in intermediate care and my ongoing role as a clinician. I therefore needed to ensure that I was interpreting as accurately as possible the participant's responses as opposed to inflicting my own perspectives.

However, in participating in the construction of responses I recognised that I could not be totally independent of the process, could not "bracket" preconceived ideas and knowledge and that there remained the risk of unconscious bias in the analysis due to the effect that a priori knowledge and experiences will have on the interpretation.

2. The data produced is the recollection of the experiences of the individuals at the time that I was talking to them and reflect the stage that both they and their service were at. There is no way of

verifying that this reflection is factually accurate as it is based on individual perception, as they perceive it. There may also be a discrepancy of this reflection if the interviews had taken place at a different point in time in that the participant's views about their experiences may have differed due to the passage of time or potentially the occurrence of other events. Events, reported by the participants, during the interviews may therefore have been embellished or inadvertently missed out.

3. The participants all volunteered to participate in the study, therefore it could be extrapolated that they had an interest in the topic of interprofessional collaboration. Others, who did not volunteer, may have provided a different perspective that perhaps was not as positive as that reported by those participating.
4. The actions of commissioners and strategic managers were not viewed in a positive light, with their knowledge and decision making abilities significantly criticised. These were discussed without the opportunity for them to defend themselves and provide their own version of events. Insight into their decision making may have offered a different perspective within the analysis.
5. Participants reported their workplaces as environments where it was possible to speak openly, to challenge the status quo and reflect on practices, agreeing on changes to these within the format of their operational meetings. There was no evidence of the maintenance of rigid professional stereotypes, with staff in all services working flexibly across traditional professional boundaries. It is accepted that this flexibility was greater in some areas than in others. Whilst participants accepted the service based guidelines for behaviour, there was no evidence that this would bring them into conflict with the standards of behaviour required by their regulatory bodies. In hindsight an omission of the interview process was to ask them what action they would undertake if such a conflict did arise.

6. The services participating in this study were located close to each other geographically. Services from different locations or organisations may have been useful to use as a comparator with those in the study.

7.7 Summary

The findings of this study have practical implications and can offer insight for those working in, or involved in, the development of intermediate care services. At the outset of the study the aim was to explore the experiences of individuals working in an interprofessional capacity within intermediate care services. At the close I have come to realise that interprofessional collaboration remains in a state of being in constant flux even where there is the perception that it is operating effectively.

Despite this, there were commonalities between all the services within this study, which resulted in the emergence of the 4C's of Interprofessional Collaboration. Participants, positively, demonstrated a willingness to collaborate with their colleagues, endeavouring to maintain open lines of communication. They utilised "**Facilitating Interaction**" to negotiate a consensus of meaning and decision making, often using coping strategies to manage the demands of internal and external stressors placed upon them. This, along with the state of Dynamic Consistency and the emergent theory offers a useful model in how interprofessional collaboration is created and sustained, for those tasked with redesigning services to encourage greater integration.

Health and social care services continue to be expected to offer high quality services, often with limited resources to do so. It is hoped that this study will therefore provide insight, and a rich interpretation of the data, for those commissioning and redesigning services, into how the participants interacted with each other to respond to the pressures they faced when working in an integrated way within the context of the intermediate care settings.

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Appendix 1 – Ethical Approval



Health Research Authority

NRES Committee East of England - Norfolk

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS
Telephone: 01158839390

27 August 2014

Dear Mrs Mottram

Study title: **Interprofessional collaboration: how is it created and sustained in intermediate care?**

REC reference: **14/EE/1109**

IRAS project ID: **158592**

Thank you for your letter of 26th August 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Assistant Tad Jones, NRESCommittee.EastofEngland-Norfolk@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

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>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an

amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research 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” above).

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Covering letter]	1	18 July 2014
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity form]	1	14 June 2013
Interview schedules or topic guides for participants [Interview guide]	5	26 March 2014
IRAS Checklist XML [Checklist_23082014]		23 August 2014
IRAS Checklist XML [Checklist_08082014]		08 August 2014

IRAS Checklist XML [Checklist_12082014]		12 August 2014
Letters of invitation to participant [Participant's letter]	2	18 July 2014
Other [Provisional opinion - response to REC]	1	23 August 2014
Participant consent form [Consent form]	1	05 March 2014
Participant information sheet (PIS) [Participant information sheet]	3	17 March 2014
REC Application Form [REC_Form_12082014]		12 August 2014
Referee's report or other scientific critique report [Progression report]	1	04 January 2014
Research protocol or project proposal [Research protocol]	4	10 July 2014
Summary CV for Chief Investigator (CI) [CV]	1	13 April 2014
Summary CV for supervisor (student research) [Academic CV]	1	11 August 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance>


We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

14/EE/1109

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Michael Sheldon Chair

Email: NRESCommittee.EastofEngland-Norfolk@nhs.net

Enclosures: *"After ethical review – guidance for researchers" [SL-AR2]*

Copy to: *Mrs Anita Mottram Mr Jon Todd, Calderdale and Huddersfield NHS Foundation Trust*

Appendix 2 – Research Information Sheet

Version 3 17/3/2014



Research Participant Information Sheet

Name and contact details of researcher:

Anita Mottram – email:

I would like to invite you to participate in the following research study:

“Interprofessional collaboration: how is it created and sustained in intermediate care?”

Please take time to read the following information in order to help you decide if you would like to take part. I would be happy to go through the information sheet with you if you wish and answer any questions you may have about the study.

Aims of the research

The aim of the research is to explore your experiences of how the team you currently work in has developed to work in an interprofessional way to manage client intervention.

By understanding further the interactions between the different professions the aim of this research is to discover what is required to enable interprofessional collaboration to work, but also to highlight where there are difficulties to developing this way of working.

This research is being undertaken as part of my studies for a PhD.

Why have you been asked to participate?

You have been invited to participate in this research because you currently work in an interprofessional intermediate care team. The focus of the research is on the experiences of people who work in intermediate care and I am inviting staff from different professions to discuss these. The information that you provide will therefore assist in finding out what factors contribute to the development of interprofessional collaboration in

these teams so that the information obtained may be used to help in the development of future teams.

Participation in the research is entirely voluntary and you are able to withdraw from the research prior to the analysis stage and the information that you have provided will not be included in the final report.

Do I have to take part?

There is no obligation to take part in this research. If you do feel you would like to contribute to it then you will be given a copy of the information sheet to keep and will be asked to sign a consent form.

If you do decide to take part you will still be able to withdraw up to the point of analysis of the data without giving a reason for doing so.

Will all my details be kept confidential?

All information which is collected will be kept strictly confidential and anonymised during the analysis stage and before the data is presented in the thesis, in compliance with the Data Protection Act and ethical research guidelines and principles.

The identity of research participants will be protected by pseudonym in the final presentation of works.

Data collection

Data will be collected using one to one interviews which will take place at a convenient time for yourself and in your workplace in order to ensure that the time taken out of your work commitments is kept to a minimum.

If however you would prefer to be interviewed away from your workplace then this too can be arranged.

The interview will be recorded in order to ensure that an accurate record of your comments has been obtained. Once the interview has been transcribed and anonymised, you will be able to check it for accuracy. The recording of the interview will then be destroyed and the transcription will be kept in secure conditions by the University of Huddersfield for a period of 5 years after the interview, after which it will be disposed of securely.

The time spent participating in this study should be no more than 2 hours. This includes approximately an hour for the interview and then some additional time after this in order to review the transcript of the interview for accuracy.

What will I be asked?

I will be asking you to reflect on your experiences of working in your existing team. This will include the background to how the team developed, or if you were not in the team at that stage, I will ask about your induction as a new member of staff into the team.

In addition questions will also be asked about how the different parts of the team works together to support clients from the point of admission onto the service to the point of discharge.

It would be helpful if prior to the interview you could think of the process that this takes so that we may discuss it. It may help to consider the interventions that have been provided to a specific client as a basis for the discussion. No personal information relating to the client will be required during the discussion process – just how the team has worked together to support them.

There will be no right or wrong answers to the questions that are asked of you – the remit of the interview is to obtain an overview of your perspective of how the team operates.

The researcher

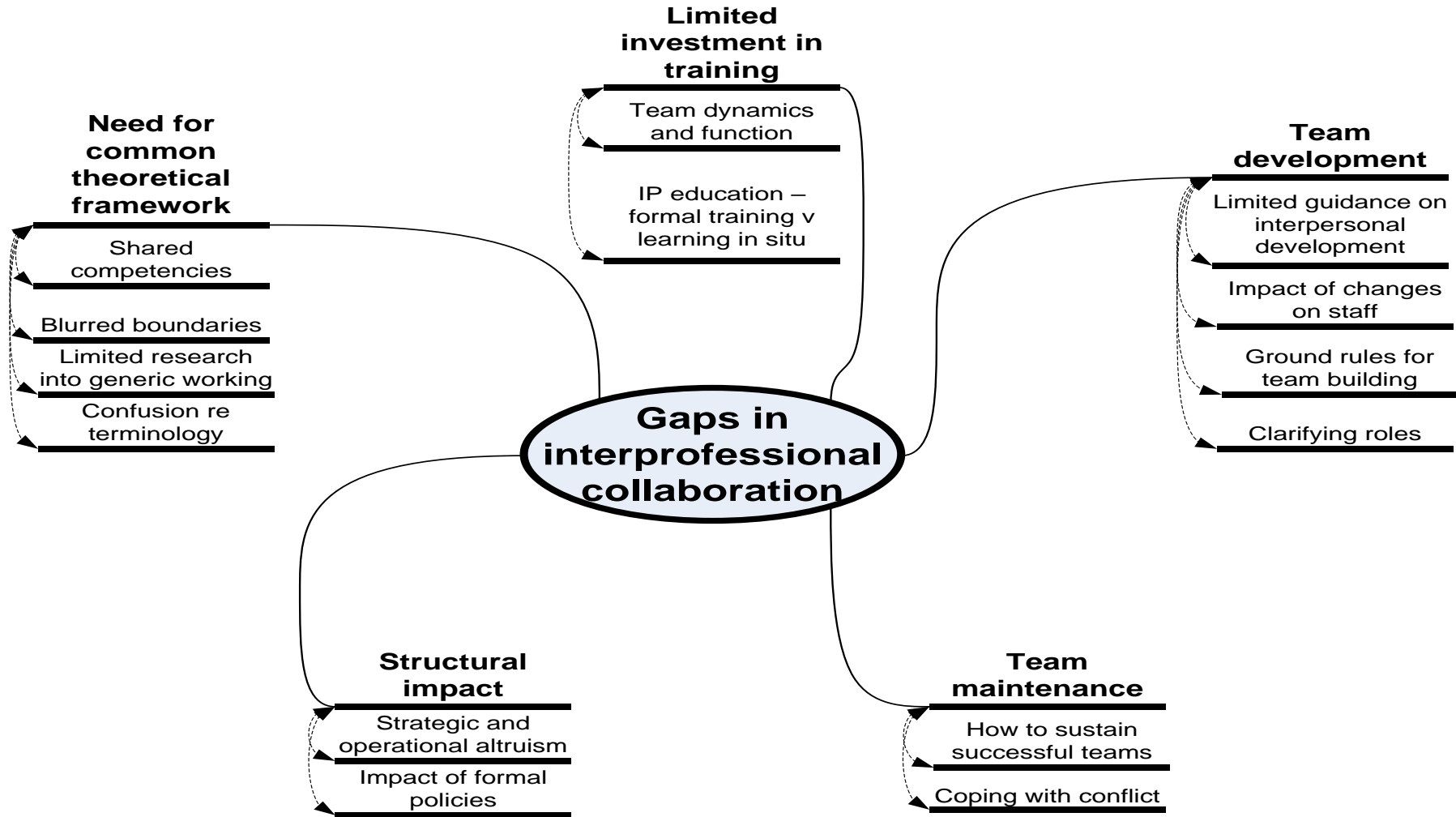
I am a part time PhD student who is interested in exploring the factors that lead to the development of interprofessional collaboration among teams working within an intermediate care setting.

My clinical background is as an Occupational Therapist and I currently manage a health, social care and housing team in Kirklees.

Conflicts of interest

This study is not funded by any external organisation. No conflicts of interest therefore are present in the exploration of this topic.

Appendix 3 – Sensitizing Concepts



Appendix 4 – Interview Guide

Version 7 – 9/02/15

Interview guide and prompt questions – Anita Mottram

Introduction

- Introduce self and thank participant for agreeing to be interviewed.
- Go through participant information sheet with them and the consent form.
- Remind them of anonymity of the data post interview and of confidentiality
- Reinforce purpose of the study – emphasis on the experiences of those working with other professions within an intermediate care team.
- Explain to participant that they do not have to answer any questions they do not feel comfortable with.

Warm up questions - personal information

1. Tell me about yourself professionally – what is your profession and how long have you been qualified
2. What is the name of the team that you work in?
3. How long has the team been in operation?
4. How long have you worked within the team?
5. What is your role within the team?

Team circle

List anyone who may be involved with the patients with whom you deal. Put those that you consider to be part of the core team on the inside of the circle and anyone else that you may network with on the outside.

1. Professional construction of team and location

Prompt: professions involved, position with the diagram, co-located or virtual team, perception of collaboration, networking

2. Development of the team

Prompt: background to creation of team, developing relationships, team development practices, development of culture, leadership

3. Type of clients dealt with

Prompt: remit of the team, criteria, referral processes

4. Decisions relating to interventions

Prompt: clinical reasoning, information exchange, collaboration, disharmony, skills, competencies

5. Team member interaction

Prompt: how the different team members work together and make decisions both operationally and clinically, collaboration, team values, managing relationships

Future of the team

Potential changes to practice

Prompt: If resources were unlimited what would you change about the way that the different professions work together in the team?

Closure

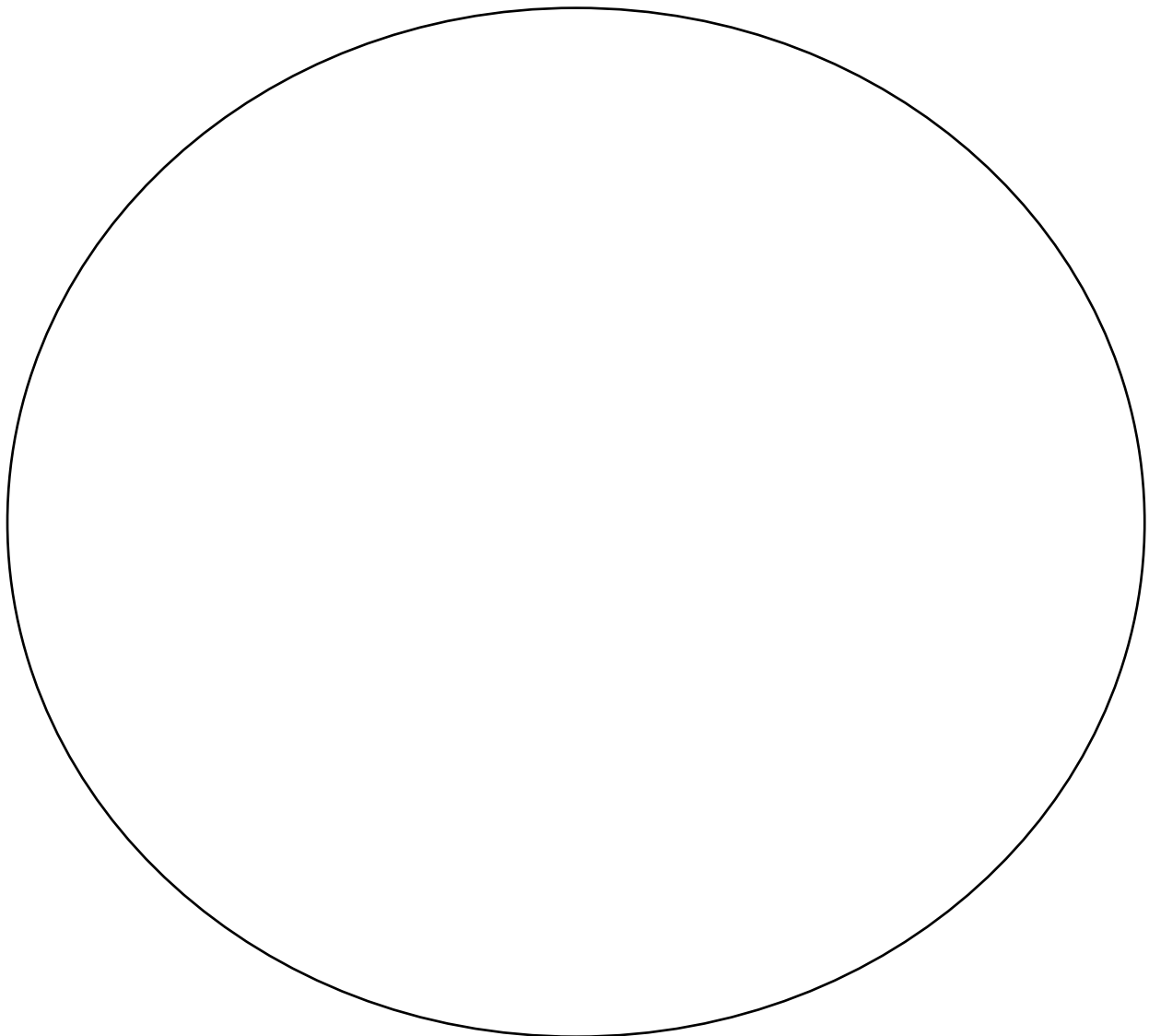
- Thank participant for their time
- Ask if they have any questions they would like to ask
- Inform them that they will be sent a transcript of the interview and that if there is anything that they feel is incorrect within it, to let the researcher know

Appendix 5 – Team Circle Diagram

Team circle

The aim of this exercise is to ascertain how professionals network during the course of providing interventions to clients.

- In the circle below write down the job titles or positions of people that you consider to be part of your immediate team.
- Write those you consider are part of your wider network (but not in your team) on the paper outside of the circle.
- There are no right and wrong answers. You will be given an opportunity to discuss the team circle during the interview.



Appendix 6 – Consent Form

Version 1 05/03/2014



CONSENT FORM

Title of Research Project: *Interprofessional Collaboration: how is it created and sustained in Intermediate Care?*

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research

I consent to taking part in it

I understand that I have the right to withdraw from the research at any time
up to the point of final analysis without giving any reason

I give permission for my words to be quoted (by use of pseudonym)

I understand that the information collected will be kept in secure conditions
for a period of five years by the University of Huddersfield

I understand that no person other than the researcher/s and facilitator/s will
have access to the information provided.

I understand that my identity will be protected by the use of pseudonym in the

thesis and that no written information that could lead to my being identified will be included in any future report.

If you are satisfied that you understand the information and are happy to take part in this project please put a tick in the box aligned to each sentence and print and sign below.

Signature of Participant: _____	Signature of Researcher: _____
Print: _____	Print: _____
Date: _____	Date: _____

(one copy to be retained by Participant / one copy to be retained by Researcher)

Appendix 7 – Transcribing Guidance

Transcribing guidance for the research study

“Interprofessional collaboration in intermediate care: how is it created and sustained?”

Thank you for offering to help me out by transcribing my interviews for me for the study identified above.

Due to the study involving interviews with participants then I would ask that you please recognise the confidentiality of the content and in line with research codes of conduct and ethical practice require that you sign a Confidentiality Agreement which confirms that you agree to ensuring that the content of the research is kept confidential between yourself as transcriber and myself as researcher.

I would ask that the content of the interviews is not discussed with anyone other than me due to this principle, recognising that the participants have provided information on the understanding that this is maintained.

Content of transcription

As the research is an exploratory study of individual’s experiences then the intent is to obtain data that is as rich and as comprehensive as possible to interpret.

This study therefore requires **full verbatim transcription**.

As well as the actual words spoken, what will also need to be transcribed is the participants’ tone of voice, any pauses or hesitation that they undertake and any non-verbal communication for example laughter, sighs.

You may also indicate where there has been an emotional response, for example shouts, sounds angry.

This allows for the contextual element of the interview to be maintained, i.e. the style in which the conversation flowed.

On the first page of the transcript include:

- Interviewee's pseudonym.
- Date and location of the interview.
- These will be indicated verbally at the start of the interview by the researcher.

Formatting

- Use double spacing
- Include line numbers for both participants and researcher
- In order to allow for hand written notes to be placed on the transcripts, provide a margin of a least one inch to the left, right, top and bottom.
- Use Arial 12 font
- Include a page number at the bottom centre of each page in the footer.
- Include a header on every page with the pseudonym of the participant on the right hand side.
- Identify the phrases undertaken by the participant by indicating these with a "P" at the start of their comments, and by the researcher by noting a "R" at the start of her comments.
- Type the questions by the researcher in bold.
- Justify the responses of the participant to queries by the researcher.
- Use normal, grammatically correct punctuation however where a participant talks in a way that is not grammatically correct then please document the transcription exactly as they have spoken but type [sic] immediately after the phrase to indicate that the transcription reflects the actual interview rather than being an error in transcription.

- Where it is not possible to be clear about what either the participant or researcher has said then please do not guess what it may be but type the word “inaudible” in parentheses and in bold – **(inaudible)**
- Where there are questions or comments that are unfinished please indicate these with ellipses - ...
- Document non-verbal communication using brackets [], for example [laughing]
- Where a participant states that they have said something to another person then indicate this as a quote using double quotation marks, for example “I told him that it would work if we did it this way”.
- Please use italics to indicate where a participant has emphasized a particular word or phrase, for example I really, *really* didn’t enjoy that meeting.

On completion of transcription

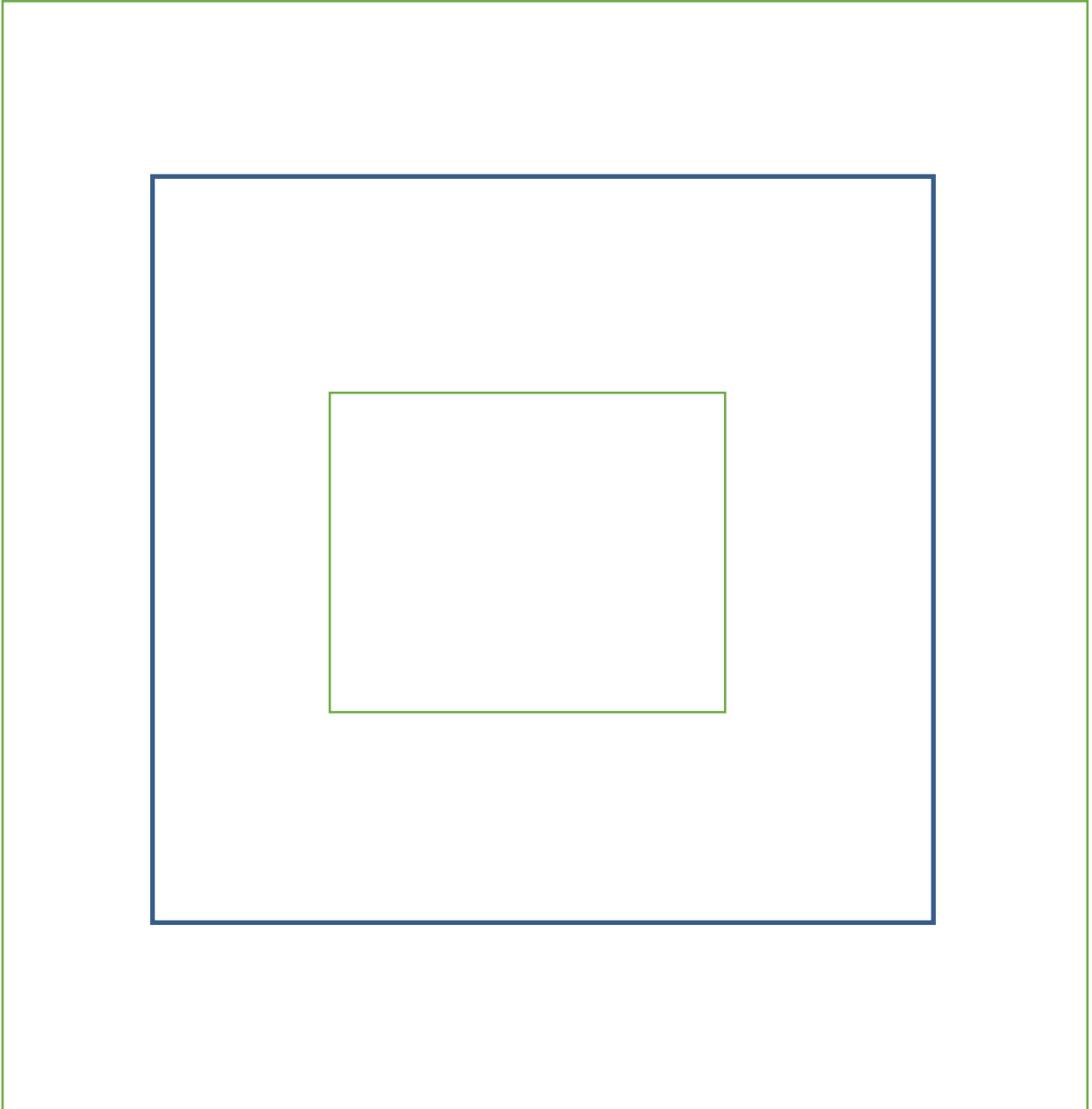
- Please email the transcription to me at _____
- I will confirm receipt of this and ask that you then destroy all data in the form of the original recording and transcript.

Many thanks once again for your help,

Anita Mottram

Appendix 8 – Locating the categories diagram

Locating the categories



Appendix 9 – Extract of a transcribed interview

PT 4 interview

R: So how did it all change, how did it go from the previous team to the [name of team]?

P: How did it change? It changed because **the organisation told us that we had to! (1) We didn't have any choice (2)**, it was sort of a **done deal that it was going to happen. (3)** We knew that **integration was part of the national policy (4)** but when it actually came to actually happening, it was, as often happens in these big organisations, **short notice really for us (5)** kind of on the ground.

1. Being told what to do

2. Having no choice

3. Recognising decisions already made

4. Being aware of legislation

5. Lacking notice

R: So how much notice were you given?

P: To me it **only seemed like a few months, (1)** I can't quite remember now. Err 2 or 3 months at the most was the kind of notice that things were going to happen. It **affected us as a team (2)** less as we were based here and remaining here. We had 2 offices that were just for us and **those 2 offices were then going to be shared (3) with the new extended team. (4)** The others

were based over at [name of building], so it was a **much bigger upheaval for them (5)** to change offices, to come into our personal space as it were.

1. Having restricted time frame

2. Affecting relationships

3. Sharing the location

4. Joining others

5. Considering other's perceptions

R: Yes, so it was the integration of the two teams together, was that the main change?

P: Yes, it was a social integration (1).

1. Merging services

R: So how did you feel about that then, people coming into your space?

P: It were a bit challenging I think for the whole team (1) because you had to do lots of jobs very quickly erm in terms of **creating more space (2)** erm for others to fit into and you had to put kind of **new desks up and around. (3)** So, in fact the whole environment had to change because you had to **make space for more people and computers. (4)** A lot of **the storage and literature things that we had had to go (5)** cos **there was not enough room (6)** for them. **Filing cabinets and things had to be merged together (7)** so there was a **lot of practical issues**

of things to do (8) and people were coming in that you didn't know. (9)

1. Considering other's perceptions

2. Changing the environment

3. Managing resources

4. Moving others in

5. Changing the environment

6. Describing difficult office environment

7. Managing resources

8. Undertaking actions

9. Moving others in

R: So how did you develop those relations? What work was done in terms of how the teams were going to be integrated?

P: There ... I don't know, we may have had a couple of workshops (1) in terms of it but, I don't really know, (2) it is a bit ago. I really don't quite remember. The main thing I think that worked well (3) here was that [name of previous manager] who was the boss at the time determined (4) that it wasn't going to be a you go in that room and we will go in this one. (5) She was determined about that, (6) the allocator was going to sit in that space and the boards were going to be there (7) and she erm kind of flung us together (8) if you know what I mean to get us to work together. Whereas in other teams

the teams are much more separate (9) for example [name of two localities] as they went into an office that wasn't theirs and so have stayed separate. If you don't **share your working environment (10)** then **I don't know that the same relationships have built up (11)** compared to ours. I remember the first Christmas do that we had after the team had joined and there was only the team leader and her deputy and they stood kind of in the corner as it felt so much **like a them and us. (12)** We were trying not to, **we were trying to include them, (13)** whereas now this Christmas it will be different, if that were a sign of any integration, **there won't be that difference (14)** between us.

- 1. Attending workshops**
- 2. Feeling uncertain**
- 3. Identifying positives**
- 4. Recognising leadership decisions**
- 5. Encouraging integration**
- 6. Standing her ground**
- 7. Managing resources**
- 8. Encouraging integration**
- 9. Working in divisions**
- 10. Sharing the location**
- 11. Recognising relationships**
- 12. Working in divisions**

13. Being proactive

14. Indicating change

R: Was there anybody or any people who were particularly challenged by it and found it difficult to cope with the merger as it were?

P: Yeah, yeah, there were erm, I think, probably less for the qualified staff (1) in some way than the assistants. They found it difficult, (2) I think we all found it difficult with the environment being a lot noisier (3) because your office space is where you sit in and do your work at the computer (4) and there were constantly people in and out (5) and the practical things like the car park space (6) and general space for things and head space. I think people found that a bit challenging. (7) Some people found it a lot more difficult than others did, for different reasons. Some people found it because we changed uniform. (8)

1. Having less impact on clinicians

2. Considering other's perceptions

3. Describing difficult office environment

4. Describing the location of the team

5. Highlighting movement of people

6. Lacking parking facilities

7. Considering other's perceptions

8. Changing uniforms

R: Right so it wasn't just your work space it was your identity as well?

P: Yeah, yeah and I didn't like changing uniform. (1) I had been in a white physio uniform that I had been in all my working life, (2) you know that I had worked hard for, and then every professional and every grade (3) suddenly all wearing the same thing. (4) That was kind of err threatening. (5)

1. Disagreeing with decision

2. Noting consistency

3. Including all staff

4. Sharing identity

5. Feeling concerned

R: Was any work done to try and, you know, work through that for individuals to try and erm ... make people move away from their professional identity?

P: No I think in a way it was a minor issue (1) that we might worry about that compared to the bigger changes (2) because there were a lot of big changes going on, the integrated services were coming in. (3) They were changing our computer systems (4) so lots of really very big things were happening (5) so the smaller, comparatively smaller things you know like, I remember saying to one of the managers (6) we don't look

smart because we had had black and white before and changed to navy blue and to me navy blue and black didn't look smart. I said even in Tesco's **you have a corporate image. (7)** They said it's not a fashion show, just get on with it. They are **very minor issues in many ways. (8)**

1. Recognising priorities

2. Managing change

3. Encouraging integration

4. Changing technology

5. Coping with change

6. Talking to others

7. Comparing image

8. Recognising priorities

R: A key point you mention is the impact on professional identity. You say that you have worked hard to become a physio, with all the post qualification things. How did people work that through?

P: Well, [small laugh], I don't think we worked it through in any other way than **sitting and having a moan in the office, (1)** [laugh] which we often do and those at **band 7 made a conscious decision (2)** to put the uniform on **and role model (3)** erm, **encouraging people (4)** towards wearing them. It got to a point where you say to them **"look come in on Monday with your new uniform on now." (5)** You know, people were **just sort of**

holding on not wanting to, (6) which in my mind I wanted to hold onto as well. So I think, **I don't remember lots of work going on in terms of the integration. (7)** It was people **working as a team (8)** between ourselves and **dealing with it. (9)** But it was my perception we had, and **still have, a good team (10)** and **there is good communication between us (11)** which helps.

- 1. Talking to others**
- 2. Taking leadership decision**
- 3. Behaving as a role model**
- 4. Encouraging colleagues**
- 5. Instructing colleagues**
- 6. Resisting change**
- 7. Lacking formal development**
- 8. Working in conjunction with others**
- 9. Managing situation**
- 10. Expressing feelings**
- 11. Talking to others**

R: So that is a multitude of different professionals, with their own different perspectives. So how do they collaborate, how do they work together?

P: We do a lot erm, a number of things, a lot of informal. (1) We sit in the office and speak (2) and that's probably the really

valuable thing (3) that's never really recorded. It is valued time because we erm, that has lots of benefits. You work with **colleagues you come to respect (4)** and **you know what their abilities are (5)** and you **trust them. (6)** So you work on that level informally for things like stroke. **We have a weekly multi-disciplinary meeting (7)** to discuss patients **so that is more formalised. (8)** We are trying to develop another more formalised structure where the more complex patients we have more case conference type meetings that are more recorded down. I **meet with the MS nurse once a month. (9)** That started off informal but is becoming more formal now. Erm, if the assistants have got any queries **they will come and speak to us. (10)** You **just get to know and are comfortable with people. (11)** Folk you don't know **you don't have the same confidence (12)** to go and ask do you? **You suss people out. (13)**

- 1. Acting informally***
- 2. Talking to others***
- 3. Recognising importance***
- 4. Valuing others***
- 5. Knowing what other's abilities are***
- 6. Trusting each other***
- 7. Participating in team meeting***
- 8. Providing structure***
- 9. Getting together***

10. Talking to others

11. Recognising relationships

12. Recognising how people work differently

13. Increasing awareness of others

Appendix 10 – Results of the Team Circles Exercise

Participant	Professions within the circle	Professions outside of the circle
<u>IC 1</u>		
OT 1	Anyone who is involved with the client – she included family as well as clinicians	Did not put anyone outside of the circle
PT 1	Assistant practitioner, community neurological rehabilitation team, community rehabilitation team	Community occupational therapy, enabling team, in patient services, Parkinson’s Disease nurse, wheelchair services
PT 2	Nurse, physiotherapist, re-ablement team	Community equipment stores, GP, home care, orthopaedic consultant, rehabilitation assistant
PT 3	Assistant practitioners, physiotherapists	A&E, community occupational therapy, orthopaedic consultant
<u>IC 2</u>		
OT 2	Community occupational therapy, dietician, <i>physiotherapist, speech and language therapy</i>	Single point of contact
OT 3	Administrative staff, allocator, dietician, falls prevention workers, <i>physiotherapist, podiatrist, speech and language therapist</i> , re-ablement staff, rehabilitation	Community occupational therapy, community equipment stores, district nurses, GP, handy person’s service, intermediate care beds, mental health teams,

	assistant, team leader	social services, specialist nurses, voluntary organisations
PT 4	Allocator, assistant practitioners, dietetic, manager, nurses, occupational therapist, physiotherapist , podiatrist, speech and language therapist	Community occupational therapy, district nurses, Multiple Sclerosis nurse, single point of contact, social worker, wheelchair services
N1	Administrative assistant, allocator, nurse, occupational therapist, physiotherapist , podiatrist, re-ablement assistant, receptionist, rehabilitation assistant, speech and language therapist	Did not put anyone on the outside of the circle
IC 3		
OT 4	Care staff, doctors, nurses , occupational therapists , physiotherapists , social workers	Charitable organisations, Community occupational therapy, community mental health teams, community rehabilitation team, re-ablement team, single point of contact for referrals
OT 5	Nurses , occupational therapists , physiotherapists , rehabilitation assistants, social workers	Community matron, community occupational therapist, community rehabilitation team, enablement team, hospital

		based staff, Mears, speech and language therapists, social worker
OT 6	Nurses, occupational therapists , pharmacist, physiotherapists , rehabilitation assistants, social services, team leader	Building services, community teams, hospital/acute services, loan stores, Mears, transport
PT 5	Co-ordinator, consultant, family, GP, nurses , occupational therapists , patient, pharmacist, physiotherapists , rehab assistants, social services	Community rehabilitation team, CPN, dietician, enablement team, podiatry, SALT
PT 6	Consultant, GP, nurses , occupational therapists , pharmacist, physiotherapists , SW, team leader, rehabilitation assistant	Acute teams, Community rehabilitation team, patient transport
N 2	Co-ordinator, consultant, GPs, nurses , occupational therapists , pharmacy technician, physiotherapists , rehab assistants, social services, team leader,	Continence service, dietician, district nurses, podiatrist, speech and language therapists, ward based staff
N 3	GP, nurses , occupational therapists , physiotherapists	District nurses, podiatry, social worker, tissue viability nurse
IC 4		
OT 7	Mental health practitioners, nursing , occupational	Acute colleagues, adaptations service,

	therapists , patient and family, physiotherapists , social workers	community occupational therapy, community matrons, community mental health team, district nurses, equipment services, GP, nursing home team, stroke discharge team, telecare, transport
PT 7	Assistant practitioners, intermediate care matron, mental health practitioners, nurses, occupational therapists, physiotherapist , rehab assistants	Community matrons, community rehabilitation team, district nurses, re-ablement team, stroke team
PT 8	Assessors, assistant practitioners, mental health practitioners, nurses, occupational therapists , pharmacist, physiotherapist , re-ablement team, therapy assistants	Community rehabilitation team, consultants, GP, inpatient teams
N 4	Nurses, occupational therapist, physiotherapist	Family and patient, managers, rehabilitation assistant, single point of contact, therapists, ward based staff
N 5	Assistant practitioners, district nurses , GPs, occupational therapist, physiotherapist , re-ablement teams, single point	Did not put anyone outside of the circle

	of contact, social workers, ward based staff	
IC 5		
OT 8	Assessors, business support, locality managers, occupational therapists, physiotherapists	Community occupational therapists, community rehabilitation team, district nurses, elective orthopaedic rehabilitation, in-patient staff, GPs, MacMillan rehab
PT 9	Locality managers, physiotherapists, occupational therapists	Therapy assistants
N 6	Business support, nurses, physiotherapists, occupational therapists	Community occupational therapy, community rehabilitation team, district nurses, single point of contact, social services, ward staff
OT 9	Occupational therapists, physiotherapists, therapy assistants	Community advice and support team, community rehabilitation team, condition specific nurses, consultant, intermediate care services, supported discharge team, social worker, ward based staff, wheelchair services

Appendix 11 List of Codes

"Awareness of others"

Interacting with others

- **Talking to others**
- **Seeking reassurance**
- **Working with partners**
- **Engaging with others**
- **Working well together**
- **Valuing talking together**
- **Seeking support from colleagues**
- **Making time for discussion**
- **Sharing information**
- **Networking with others**
- **Talking through change**

Showing an affinity for colleagues

- **Listening to each other**
- **Imitating others**
- **Being kind to others**
- **Sharing the load**
- **Demonstrating empathy**
- **Trusting each other**
- **Caring for others**
- **Considering other's perceptions**
- **Supporting each other**
- **Expressing feelings**
- **Respecting each other's views**
- **Making self available to others**
- **Valuing others**
- **Encouraging others**
- **Being genuine**
- **Building trust**

Being aware of other's abilities

- **Recognising others skills**
- **Knowing what other's abilities are**
- **Knowing other colleagues**
- **Complimenting colleagues**
- **Understanding each other's roles**
- **Recognising how people work differently**
- **Questioning other's roles**
- **Ensuring right person for the job**

"Managing relationships"

Developing relationships

- **Getting together**
- **Recognising relationships**
- **Respecting diversity**
- **Sharing decision making**
- **Building rapport**
- **Having discussions between group members**
- **Seeking information about clients**
- **Meeting new people**
- **Having professional relationships**
- **Recognising how people work differently**
- **Bringing people together**

Facing challenges from others

- **Lacking knowledge of role**
- **Difficulty communicating with others**
- **Having strained relationships**
- **Putting barriers up**
- **Affecting relationships**
- **Creating barriers**
- **Breaking up service**
- **Losing face to face contact**
- **Failing to involve others**
- **Working in localities**
- **Getting resistance from colleagues**

Promoting collaboration

- **Sharing identity**
- **Signposting to others**
- **Working in an integrated way**
- **Working in conjunction with others**
- **Sharing responsibility with others**
- **Encouraging integration**
- **Participating in team meeting**
- **Contributing to team cohesion**
- **Working in an integrated way**
- **Collaborating unconsciously**
- **Enjoying working together**
- **Sharing skills**
- **Working holistically**
- **Working across professional boundaries**
- **Transitioning to integration**

"Experiencing professional issues"

Expressing dis-satisfaction in employment

- **Being uncertain about roles**
- **Feeling unappreciated**
- **Expressing concern**
- **Lacking information**
- **Challenging time**
- **Feeling under pressure**
- **Having no choice**
- **Lacking morale**
- **Recognising workload pressures**
- **Recognising difficulty of role**
- **Feeling concerned**
- **Deteriorating situation**
- **Working in divisions**
- **Experiencing adverse event**
- **Lacking support from the organisation**
- **Feeling disillusioned**
- **Fearing for the future**
- **Feeling isolated**

Reinforcing professional practice

- **Working to core professional standards**
- **Promoting profession**
- **Impacting on junior grades**
- **Protecting own roles**
- **Maintaining professional responsibility**
- **Having the confidence to act**
- **Knowing own competencies**
- **Being proactive**
- **Being accountable**
- **Having professional relationships**
- **Standardising practice**
- **Transitioning to integration**

Reflecting on practice

- **Working across professional boundaries**
- **Having problems communicating**
- **Hoping for improvement**
- **Reflecting on actions**
- **Querying other's processes**
- **Offering professional equity**
- **Demonstrating professional maturity**
- **Realising limitations**
- **Being consistent**
- **Feeling stabilised**
- **Working autonomously**
- **Protecting own roles**
- **Keeping an open mind**
- **Working successfully**
- **Knowing their own competencies**
- **Describing undergraduate training**

"Administering change"

Changing the service

- **Changing paradigms**
- **Coping with frequent change**
- **Managing change**
- **Resisting change**
- **Making change work**
- **Being told what to do**
- **Frequency of change**
- **Breaking up the service**
- **Being aware of potential change**
- **Lacking information about change**

Reviewing processes

- **Lacking development work**
- **Introducing new ways of working**
- **Losing way**
- **Talking through change**
- **Feeling uncertain**
- **Looking objectively**
- **Thinking differently**
- **Devising coping strategies**
- **Moving boundaries**
- **Suggesting changes**
- **Making decisions about the service**
- **Reviewing pathways onto service**
- **Keeping an open mind**

Impacting on infrastructure

- **Describing the location of the team**
- **Lacking resources**
- **Merging services**
- **Describing difficult office environment**
- **Lacking parking facilities**
- **Using technology**
- **Managing resources**
- **Removing staff**
- **Moving others in**
- **Recognising strategic input into decision making**
- **Lacking staff capacity**
- **Changing the environment**
- **Sharing the location**

"Undertaking interventions"

Managing the episode of care

- **Providing clinical interventions**
- **Working flexibly**
- **Making clinical decisions**
- **Undertaking assessments**
- **Managing complex cases**
- **Maintaining people at home**
- **Receiving referrals**
- **Experiencing adverse event**
- **Working autonomously**
- **Using robust clinical governance**
- **Producing clinical records**
- **Accepting a referral**
- **Admitting patients**

Learning whilst doing

- **Undertaking further training**
- **Increasing understanding of the role**
- **Participating in in-house training**
- **Undertaking situated learning**
- **Learning from each other**
- **Observing others**
- **Obtaining feedback from others**
- **Participating in professional socialisation**
- **Seeking clarification**
- **Learning together**
- **Describing under graduate training**
- **Changing paradigms**

Appendix 12 Stressors articulated by the participants

Stressors identified	IC1	IC2	IC3	IC4	IC5
<u>"Facing challenges from others"</u>					
Facing demands from the hospital to free up beds	X			X	
Uncertainty of own role and that of others			X	X	X
Challenging relationships between strategic managers from different organisations which impacts on decisions about the service			X		X
<u>"Expressing dis-satisfaction in employment"</u>					
Pressure to meet performance indicators/targets	X				
Feeling stressed in the job	X	X	X	X	X
Fearing for the future of the service	X	X	X		X
Feeling isolated within the role due to nature of community working	X	X			
Decreased autonomy as a clinician	X				X
Lack of recognition of professional roles by the commissioners		X	X	X	X
Feeling a lack of security in the post due to commissioning decisions		X	X	X	X
Lack of support from the organisation to encourage collaboration		X	X	X	X

<u>"Reinforcing professional practice"</u>					
Initial frustrations that others undertook tasks that participants considered to be within their role		X	X		
<u>"Reflecting on practice"</u>					
Change of uniform impacted on professional identity		X			
Concern about quality of care provided by partner agencies		X		X	
<u>"Changing the service"</u>					
Feeling unable to contribute to decisions about the future of the service	X	X	X	X	X
Concerns about the frequency of change affecting the service	X	X	X	X	X
Concerns about the impact of introducing technology	X	X			
Fearing the outcome of tendering the service	X	X			
Lack of information available about changes affecting the service		X	X	X	X

<u>"Impacting on infrastructure"</u>					
Restricted working environment – lack of space	X	X		X	
Noisy office environment affecting ability to concentrate		X		X	
Infrastructure issues – lack of computers, parking facilities		X	X	X	X
<u>"Managing the episode of care"</u>					
Concern about ability to meet the needs of the patients due to the volume of work	X	X	X	X	X
Quality of referrals received from other services, as a result of which it is perceived that the patient or practitioner may be placed at risk	X	X	X		X
Staff vacancies not replaced thereby impacting on staffing capacity			X	X	X
Increased complexity of the patient admitted to the service			X		
Psychological impact of managing difficult situations when visiting patients in their own home, for example when situations are breaking down or finding patients have passed away.		X			X
<u>"Learning whilst doing"</u>					
Shock of transitioning from student to practitioner			X		

Appendix 13 Evaluation of the study

Credibility of the study

1. Has your research achieved intimate familiarity with the setting or topic?
--

<p>A preliminary review of the literature was undertaken which identified a gap in knowledge and the limited number of empirical studies into interprofessional collaboration within intermediate care services, with which to make comparisons.</p>
--

<p>The process of concurrent data collection and analysis and transcribing the interviews personally allowed for increased familiarity of the data and the identification of new insights into the phenomenon of interprofessional collaboration.</p>

<p>Previous experience of working in the field of intermediate care also provided an underlying knowledge of the rationale for this type of service and the background to its development.</p>
--

2. Are the data sufficient to merit your claims? Consider the range, number and depth of observations contained in the data.

<p>The participant sample were all clinicians meeting the criteria for inclusion within the service and were diverse in terms of length of time in service, personal and professional maturity.</p>

<p>Determining insight into "Facilitating Interaction" was achieved through the process of theoretical sufficiency with no new concepts relating to this forthcoming from the last few interviews undertaken. No further participants were therefore sought from which to seek additional information.</p>

3. Have you made systematic comparisons between
--

observations and between categories?

Detailed analysis led to the fragments of data labelled in a way that was considered to best reflect the researcher's interpretation of the participant's meaning.

A process of constant comparison was used to subsequently compare these with other fragments to ensure consistency of labelling, sometimes leading to the labels being reviewed and altered. This recognised the different interpretation that may have been placed on the contextual situation by the researcher at the time she was initially analysing and coding the individual fragments. A summary of this process is provided in chapter four.

4. Do the categories cover a wide range of empirical observations?

Data was obtained from participants from different professional groupings, different grades, five different services and two different organisations. This ensured a diversity of experiences, strategic styles and expectations which has contributed to increased credibility for the study by offering a greater variety of information to analyse.

Due to the study sample being relatively small, assumptions cannot be made that the views of the participants are representative of the population of all staff working in intermediate care, however, they can be considered to be sufficient to generalise a theory for staff working in these or other settings.

5. Are there strong links between the gathered data and your argument and analysis?

Chapter five has demonstrated the links between the data and conceptualisation of this to generate a theory. This is evidenced through verbatim extracts from transcripts and visual images demonstrating the

abstraction of the data from coding to the creation of higher level categories.

6. Has your research provided enough evidence for your claims to allow the reader to form an independent assessment and agree with your claims?

The processes documented in this thesis will provide the reader with sufficient information to enable them to form their own opinion of the outcome of data collection and analysis.

Originality of the study

1. Are your categories fresh?

The categories generated from the data are original to this study and offer an alternative perspective of the experiences of individuals working in intermediate care settings, specifically the concept of "**Facilitating Interaction**" leading to the abstraction of *Dynamic Consistency*.

2. Do they offer fresh insights?

As findings were generated following the analysis of data obtained through semi-structured interviews, an original visual tool "Team Circles", was used within these interviews. This was an emergent method that informed the data and impacted on analysis and the findings.

The findings of this exercise reinforced the presence of subjective, multiple realities, offering a defining moment in recognising that no participants considered the structure of their teams to be identical to that of any other participant interviewed. This raised a further question of the data, of how collaboration could take place successfully if individuals interpret this composition in such different ways, eventually determining, that participants did so by negotiating meaning to create order and consistency.

3. Does your analysis provide a new conceptual rendering of the data?

As identified previously, there have been a limited number of extant studies that have explored the interpersonal relationships required to develop interprofessional collaboration within intermediate care settings. This study highlighted the significant impact that internal and external stressors had on these, and how the alliances formed to cope with them assisted in the generation of a collective identity which contributed to

collaborative practice.

When coping strategies were in situ, the collective identity, was perceived to create a greater synergy and strength between the participants than individual professional ones.

4. What is the social and theoretical significance of the work?

The theory that was generated from this abstraction was original in construction and provides the reader with greater insight into how the participants responded to stressors leading them to develop alliances and to create and sustain interprofessional collaboration through the use of the 4C's of Interprofessional Collaboration.

This offers a greater understanding and increased awareness of how and why some groups work together successfully whilst others do not. It may be used to proactively address service development during the process of organisational redesign.

5. How does your grounded theory challenge, extend or refine current ideas, concepts and practices?

The findings in this study challenge suggestions of intragroup role conflict and previous studies' perception of a pessimistic approach to collaboration. It challenges existing commissioning practices by advocating for greater engagement of operational staff in decision making relating to service re-design.

The findings contribute to the existing gap in knowledge relating to how interpersonal relationships in interprofessional collaboration are created.

Due to the emphasis on situated learning, participants questioned the extent to which formal IPE prepares individuals to collaborate, suggesting instead the importance of learning from each other within contextualised settings.

Resonance of the study

1. Do the categories portray the fullness of the study's experience?

By the end of the interviewee stage of data collection, no new concepts were identified in relation to "**Facilitating Interaction**". The notion of Dynamic Consistency as a means of maintaining order and structure through "**Facilitating Interaction**" resonated with the participants. It may also be utilised by others to explore interprofessional collaboration within other contextual situations.

In particular, responses, by the participants, to the concept of Dynamic Consistency, suggested this to be insightful as it assisted them to recognise how interprofessional collaboration, once achieved, was not a static entity but was in a state of flux, reviewed and revised depending on the situation, within the parameters of accepted practice. This provided a means of explaining how participants coped with the state of constant change, but also the extent of the adversity, that services were reported to be experiencing.

2. Have you revealed both liminal and unstable taken for granted meanings?

Participants reported that the concept of interprofessional collaboration was such accepted practice that it had become a habitual way of working, to the extent that the majority initially struggled to articulate the processes that interprofessional collaboration involved.

3. Have you drawn links between larger collectives or institutions and individual lives, when the data indicate this?

Links were made between the data from the different participants through the process of constant comparison. "**Facilitating Interaction**" and Dynamic Consistency were identified as the social processes that were of relevance to all those involved in the study.

The impact of adversity on encouraging collaborative practice highlighted significant similarities between the services in relation to these concepts.

4. Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?

The findings of the study were shared with some of the participants to seek out their views on the insight obtained. The outcome of this exercise was assurance from them that the higher level categories diagram and subsequent theory were considered to make sense for their individual interpretation of their reality.

A presentation of the research took place at a CAIPE workshop in March 2016 at the University of Huddersfield, leading to a facilitated question and answer session and subsequent informal discussion during the lunch break. During the interactions with members of the audience they suggested that the findings resonated with their own personal experiences as clinicians.

The theory developed during this study is therefore specific to the data obtained from the participants within the context of intermediate care during this period of their career, and within these services.

Usefulness of the study

1. Does your analysis offer interpretations that people can use in their everyday worlds?

This study has provided an interpretation of how individuals develop relationships in a clinical environment using processes that potentially may be replicated in other social settings through the use of "**Facilitating Interaction**", the 4Cs of Interprofessional Collaboration and Dynamic Consistency. These may be considered to be generic processes to implicitly, or explicitly, play a role in negotiating meaning to create social order by working within agreed parameters for the culture individuals are participating in. In addition this provided a means by which people developed coping strategies to manage adversity.

The findings from this study could be applied to any service working interprofessionally, whether in or outside of health care. It has compared the experiences of individuals who are working in a similar type of service and of the different key professions who are working within it.

2. Do your analytic categories suggest any generic processes? If so, have you examined these generic processes for tacit implications?

The generic processes within this study were "**Facilitating Interaction**", the 4Cs of Interprofessional Collaboration and Dynamic Consistency, with the former recognised as explicit leading to the tacit development of the latter which underpins interprofessional collaboration.

3. Can the analysis spark further research in other substantive areas?

Opportunities for further research are identified within this chapter particularly in relation to the impact of internal and external stressors on the development of interprofessional relationships, whether this is replicable in other teams, the impact of frequent change on those operationalising services and also practitioner satisfaction with strategic managers and commissioners.

There is also further opportunity to explore whether effective interpersonal relationships between practitioners impacts on the quality of intervention as perceived by service users.

4. How does your work contribute to knowledge? How does it contribute to making a better world?

This study is important because it highlights the habitual nature of interprofessional collaboration once this has developed and the internal and external factors that help contribute to this.

Despite the utopian perspective of interprofessional collaboration, the presence of stressors within contemporary health services had such a significant impact on the personal and professional wellbeing of participants, sufficient to create alliances between individuals. They supported each other through the development of collaboration assisted by the presence and strength of a collective identity which enhanced intragroup relationships.

Through this, interpersonal relationships were considered to be of greater significance than interprofessional competencies.