

Allied health professionals' roles and boundaries in the “new” NHS

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Abstract

Changes in the way health care services are delivered in England have affected the roles and boundaries of healthcare professionals. The agendas of skill mix and interdisciplinary team work have been facilitated by the migration of services into primary care. There is a growing body of research addressing the effect of healthcare organisation and delivery on the roles and boundaries of doctors and nurses. Very little research has focused on the third largest section of the professional healthcare workforce, allied health professionals. This study investigated the roles and boundaries of allied health professionals working in primary and secondary care contexts.

An ethnographic extended case based methodology was adopted. Two case studies were taken from a secondary care organisation, and two from a primary care organisation. Cases were identified in discussion with professional leads from the two organisations. Within the cases both purposeful and convenience sampling approaches were applied. Data were generated through semi-structured interviews, field work and non-participant observations. Analysis consisted of a broadly thematic approach; the emergent themes were presented within the case reports as an interpretive poly-narrative. Structuration theory provided a framework on which to develop a cross case analysis and frame the interpretations overall.

The emergent themes highlighted a number of important aspects related to professional roles and boundaries. The primary element shaping the roles and boundaries of allied health professionals was the complexity of the patient. The findings indicated a positive relationship between transparent and structured care and patient centred practice and team work. Finally and of significance was a neglect of rehabilitation within both primary and secondary care.

In order to promote inter-professional team work and patient centred practice there needs to be clarity of patient need and focus of service provision. The neglect of rehabilitation will have far reaching implications for the future.

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Abbreviations:

AfC	Agenda for change
AHP	Allied health professional
CHD	Coronary heart disease
COPD	Chronic obstructive pulmonary disease
COT	College of Occupational Therapy
CPD	Continued professional development
CSP	Chartered Society of Physiotherapy
CVA	Cardio vascular accident
DN	District nurse
DoH	Department of health
EBP	Evidence based practice
GP	General practitioner
HPC	Health Professions Council
ITU	Intensive treatment unit
KsF	Knowledge and skills framework
MDT	Multi-disciplinary team
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
OT	Occupational therapy/therapist
OTA	Occupational therapy assistant
Physio	Physiotherapy/therapist
PT	Physiotherapy/therapist
SALT	Speech and language therapy/therapist
UK	United Kingdom
US	United States of America

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Dedication:

This work is dedicated to my wife Kay, and my two children James and Lucy.

Chapter 1

Introduction

Reflecting wider global financial agendas, as opposed to individual party politics, policy agenda in the public sector is one which promotes multi and inter-professional and multi and inter-agency collaboration, role overlap and, related to health care delivery, the development of entrepreneurial professionals. Successive and incremental changes in public sector policy over the past 25 years are now set against a back drop of increasing austerity where cuts to public services appear unprecedented.

Smith et al., (2000) view the removal of professional boundaries as a key in the development of the “new” NHS. The traditional demarcations between professional groups have been highlighted in recent NHS policy as one of the main obstacles to modernising services (DoH 2000a; DoH 2006). Although it is acknowledged that professionals have played an integral part in the development of the NHS (Rivett, 1998; Baxter and Brumfitt, 2008), there is growing concern that the current organisation and allegiances of the various professions involved in the delivery of health care services prevents as opposed to assists change (Ackroyd, 1996; Baxter and Brumfitt, 2008).

Researchers and public sector professionals are interested in, and concerned about how changes in NHS policy are affecting the working practices, roles and identities of public sector professionals. Changes in how professionals involved in the delivery of health care are trained, regulated, and structure their practice have contributed to these concerns (DoH, 2000a; 2000b; 2001).

An expansion of the concept of governance within the public sector has created a plurality of actors and organisations involved in the development, regulation and control of professional practice (Newman 2006). Referring specifically to healthcare, there has also been changes to where health professionals deliver services with a

move away from the traditional hospital provision to services being provided in a number of contexts. In addition to this, there has been an increase in the provision of NHS services by the voluntary and private sectors.

The view that changes in what professionals do, how they are regulated and how they are trained somehow effects their professional identity, roles and boundaries has been put forward by Hanlon (2000). What it means to be and act like a member of a specific profession is closely linked to the day to day activities an individual is involved in (Freidson, 1970; Haferty and Light, 1995; Davis, 2002; Wenger, 1998), the language they use (Lingard et al., 2002; Apker and Eggly, 2004; Niemi and Paasivaara, 2007), their education (Hunt, 1998) and where they work (Baxter and Brumfitt, 2008). This final point is of particular interest when one considers the emphasis on services being delivered outside of the “traditional” hospital setting, as this raises the question of context and its relationship to professional identity roles and boundaries.

There is a growing body of literature focusing on how public sector professionals are responding to changes in their work and working practices. Considerable attention has been paid to teaching and social work. With regards to healthcare professionals current research addressing the changes outlined, and more specifically the relationship of context to roles and boundaries has almost exclusively focused on doctors and nurses. Although forming a significant proportion of the health workforce there has been very little attention given to how the changes outlined are affecting allied health professionals with regards to their roles and boundaries and professional identities.

Allied health professions, although not a homogenous group of professions, are seen collectively due to their shared regulation, standards of practice and ethics as defined by the Health Care Professions Council (HCPC¹). The Council currently regulates 14 professions including physiotherapists, occupational therapists and speech and language therapists.

¹ Formally the health Professions Council (HPC) the organisation changed its title in 2012 to reflect the inclusion of social workers on to the register)

Situated within the very broad discipline of sociology this research builds on the work which has gone before regarding the sociology of professional practice (Elston and Holloway, 2001) and the development of professional roles and identities (Allen 2000). This work contributes to the growing body of literature regarding public sector professional identities and roles and boundaries. By focusing specifically on allied health professionals this work provides a useful and unique insight into this section of the work force which to date has been poorly investigated.

This research provides a detailed, contextually bound account of individuals' perceptions of their roles and working practices.

The research questions are:

- How do allied health professionals perceive their current working practices and how do these fit within the larger organisation?
- How do individual professionals view their identities and roles within the multi-disciplinary team and the wider organisation?

Developed out of engagement with the literature, the following propositions frame the research questions:

- Current changes in both the context and definitions of health care activities have led to a negotiation of occupational roles and what constitutes a professional activity.
- Role negotiation and professional activities will vary depending on the context of service delivery.
- Developments in the NHS have led or are leading to the development of a new kind of health professional.

This thesis charts the development of the research questions, and the underlying propositions, and provides an account of the empirical approach chosen to address these. In order to answer the research questions and take account of the underlying propositions an ethnographic extended case study approach was chosen. Two cases were selected from a primary care setting and two from a secondary care setting located within the same geographical area. The adoption of an extended case based methodology permitted cross case analysis of the data generated. The theoretical interpretations developed from the analysis provides important insights into the roles and boundaries of allied health professionals, specifically physiotherapists and occupational therapists, which will be of interest to health service managers, professional groups and educators.

Thesis structure

The thesis consists of eight chapters.

Chapter two focuses specifically on the concept of professions as a sociological construct. The development and position of professions within social systems is considered. The chapter also explores the concept of professional identity, and the relationship of power to the interpretation of professions and professional work.

Through the exploration of professions as a sociological concept this chapter lays the foundations on which to build an empirical stance

Chapter three provides both the political and empirical context in which the research questions were formed and are framed. The chapter is divided into two sections. The first section provides a critical overview of health care policy, focusing specifically on the introduction of the internal market into the NHS, a policy trajectory which has resulted in a number of changes in how healthcare professionals work. Beginning with the changes introduced by the Conservative Government in 1989, the chapter goes on to describe and critique the trajectory of change pursued by New Labour and the current Coalition Government. The second section of the chapter reviews the empirical literature concerning how changes in the way health care services are organised have affected the work of healthcare professionals generally, and Allied health professionals specifically.

Chapter four provides a narrative account of the development of the chosen methodology. The chapter also details the chosen methods of cases study selection data generation and analysis.

Chapters five and six detail the case studies. Included in these chapters are descriptive accounts of the research sites from the cases were selected. Following these are the four case reports which contain the emergent themes generated from the data. Chapter five consists of the case reports generated from secondary care. Chapter six contains the case reports from primary care.

Chapter seven extends the analysis detailed in the four case reports through cross case analysis. Analysis across the four cases facilitated the organisation of the data into relationships and patterns and highlighted areas of overlap and divergence. Through the process of cross case analysis a number of interrelated themes emerged which form the structure of the chapter.

Chapter eight brings together the findings from the four case studies, the interpretations developed through the cross cases analysis and discusses these in the context of the social theories that frame this thesis.

The discussion begins by setting out the findings from the research and their implications. The discussion is developed by locating the research findings in relation to theoretical concepts serving to develop and question contemporary debates regarding the concept of professions and professional practice. The chapter concludes with some critical reflections on the research before highlighting what this work adds to our understanding of contemporary healthcare professional practice, and identifying possible areas for further research.

Chapter 2

Professions as a distinct group:

Key concepts in relation to this work are the terms professions, professionals and identities. The aim of this chapter is to explore these concepts in detail and provide the foundations on which an empirical investigation can be constructed.

The initial literature search involved the use of the following bibliographic data bases, Social Care Institute for Excellence, Science Direct, and Psychinfo and CINAHL Plus via Ebsco. The key words used were professions, healthcare, allied health, professionals, identity, and professionalism, with Boolean operators (and, or) used as appropriate. The search strategy was supplemented by hand searching which involved the following up of citations. The primary purpose of the literature review was to frame and refine the research questions. Literature was reviewed conceptually and methodologically and considered based on relevance to the research questions. The decision to stop the literature review was made once a coherent argument linking the key concepts embedded in the research questions had been achieved.

The chapter will firstly discuss the concept of professions as a sociological construct. Following on from this the development and position of professions within social systems will be considered. Discussion focusing on the relationship of power to the interpretation of professions and professional work will be developed. Finally identity and specifically professional identity will be explored, incorporating the terms professionalism and professionalism.

Although this chapter's focus is broadly theoretical some empirical work has been included as a means of illustrating the utility of the different theoretical interpretations discussed in light of the research questions overall.

Sociologists interested in the study of professions as a distinct aspect of the division of labour, have focused on those occupations claiming to be professions or those occupations perceived by researchers and academics to be professions (Freidson, 1994; Bourdieu and Wacquant, 1992). In contrast the branch of sociology concerned

with occupations centres on the division of labour in the more general sense, for example incorporating concepts of social class and inequalities (White, 2006). This is not to suggest that these concepts have not been addressed within the study of the professions, rather that the study of occupations as a whole has tended to focus on a more micro as opposed to a macro approach. Abbott (1993, p. 188) reviewing the literature on work and occupations concluded that:

the sociology of work and occupations has for the last 20 years pursued a fairly narrow range of topics. It has focused on individual behaviour and its immediate contexts, looking at psychology, personal, and social antecedents and consequences of work behaviour. It has largely ignored other bodies of inquiry into work. There have been few attempts at general theoretical analysis outside Marxist writings and perhaps the sociology of professions.

Extending Abbot's comments, analysis focusing on the relatively small subset of the occupations, the professions, has generated a far greater number of often conflicting interpretations, reflecting a number of different sociological paradigms. Professions have attracted a great deal of attention from sociologists mainly because of the higher rewards they receive, and their apparent homogeneity with regards to empirical investigation (Borrdieu and Wacquant, 1992). However, viewing professions as a specific subset of occupational groups has tended to lead sociologists to either define the boundaries or factors indicative of that subset or outline the processes occupations move through in order to be classified within the subset (MacDonald, 1995). In addition to this, a focus on more macro theories of professions has contributed to the creation of a concept which is highly abstract, not easily lending itself to empirical research (Larson, 1990). The delineation of professions as an analytical subset of occupations can be extended when one considers the division between public sector and private sector professions (Buelens and Van den Broeck, 2007). Contrasts have been made between professionals working in the public and private sector leading to the suggestion that a difference in values and beliefs exists between the two. Professionals working in the public sector are less committed to their organisation, displaying more allegiance to their profession (Anderson 2009; Franco et al., 2002).

Classifying occupations as professions:

The first aspect of sociological enquiry indicated above, that of identifying or classifying occupations as professions, has generated a great deal of literature for both its support and its criticism. Often referred to as the trait model of professions this line of enquiry has centred on identifying those qualities which mark out an occupational group as a profession (Carr-Saunders and Wilson, 1933). There has and continues to be a great deal of literature highlighting but also questioning the key attributes which occupations identified as professions possess (Davis, 2002). There also appears to be little agreement on exactly which traits should be included to account for all professions (Moloney, 1986).

The medical profession is often regarded as one of the prototypical professions possessing all of the desired attributes (Sullivan, 2000). Core characteristics such as practice autonomy, altruism, a defined body of knowledge and skills, control over how these are created (normally through prolonged education and eventual certification), defined ethics and scope of practice, and control over access, are often used to distinguish occupations as professions (Hoyle and John, 1995). Those professions allied, or seen as subsidiary, to medicine (such as those regulated by the Health and Care Professions Council) have been labelled “semi-professional” (Etzioni, 1969; Boyce, 1993; 2006), in that they fall short of the ideal (Burrage and Torstendahl, 1990). This has led a number of professions involved in the delivery of health care to attempt to emulate the professional ideal of medicine, often creating a tension between what they actually do when compared to what they (the profession) feel they should be doing. (Scholes, 2008; Mazhindu, 2003).

Through its control of hospitals the medical profession was until relatively recently able to structure and control the division of labour in health care in the UK. This meant in some cases, controlling the knowledge base and activities of other professions (Larkin, 1988; Ackroyd, 1996; Miles-Tapping, 1985). However, recent changes in health policy in the UK, in addition to challenges to medicine’s control over how health services are delivered in the hospital setting, have led some authors to suggest that this once archetypal profession is also failing to live up to the ideal (Thistlethwaite and Spencer, 2008).

One of the key criticisms of the trait model as a means of structuring enquiry into the sociology of the professions is that the attributes identified and listed above are often seen as a given (MacDonald, 1995). To suggest that those occupations, either self-labelled or externally labelled as professions do not exhibit shared characteristics would be naïve. However, to suggest that such characteristics are the defining attributes of a profession would be to play into the hands of one social group to the detriment of another (Larson, 1990). This argument is supported by Larkin (1983), suggesting that medicine was (is) able to dominate paramedical professions, by the virtue of its position within society, a status reinforced to some degree by sociologists in the way they define medicine as the ideal profession. Taking this stance, a criticism of the trait model of professions is the potential for members of professions to use such explanations in order to justify as opposed to explaining, their role in society. Another criticism is that there seems to be very little agreement on exactly which traits should be present (Moloney, 1986). The latter unfortunately still appears to be the case within the literature concerning professions, with a number of authors listing a variety of traits which they feel applies to the professions they are investigating (Sparkes, 2002; Chaska, 1990; Moloney, 1986). With regards to the first criticism a defence can be found in the functionalist origins of the trait model. Johnson (1972, p. 23) has stated that within functionalist classifications of occupations as professions:

there is no attempt to present an exhaustive list of 'traits'; rather the components of the model are limited to those elements which are said to have functional relevance for society as a whole or to the professional-client relationship.

Durkheim (2002) viewed professions as a “buffer”, between the state and the general population. The development of professions from a functionalist perspective therefore is regarded as an essential element in the development of industrialised societies. Professions serve society by acting as a medium between the laissez-faire ideologies of individualism and state collectivism (Johnson, 1972, p. 12). The traits associated with professions such as altruism and ethics give a sense of neutrality, setting professions apart from other occupations. Based on this the status and perceived privileges associated with profession are justified. This explanation as to why industrial society needs professions and the roles they play within society has

been criticised heavily over the past 40 years. Recently, Lunt (2008) has argued that the development of a litigation and blame orientated society has brought into question the neutrality of the professions, this being fuelled by a number of cases where professionals have been shown to be misusing their positions (Bolsin 1998). The introduction of the concept of patient centred practice, and greater external governance within health care, may be a direct result of society's lack of trust in the professions, as much as the traditional traits associated with professions now failing to reflect contemporary society. Traits which were seen to be of importance to professional practice at the start of the 20th century are being re-interpreted and restructured in order to fit within institutional and organisational expectations (Baxter, 2011). Empirically this is demonstrated in the work of Goode and Greatbatch (2005) who, when investigating nurses and call-centre workers in NHS direct, found that nurses no longer performed the role of buffer between the client and state, this role being adopted by the call-centre workers. Nurses, it appeared, had adopted the discourse of management and governance. This change in roles could be contributing to what Scholes (2008) has described as the current crisis in the professional identity of nurses.

Although criticised by a number of authors (Hugman, 1991; Saks, 1996; MacDonald, 1995; Freidson, 1994; Evetts, 2011) functionalist theory still persists in the writings concerning professional development and the relationship between professions and external bodies such as the state or client (Sparkes, 2002; Foster and Wilding, 2000). Functionalist theory and trait classifications do offer useful explanations as to the relationship between professions and the state, and provide an insight into explaining how individual professionals may see themselves (Carmel, 2006; Mazhindu, 2003; Freidson, 1994; Evetts, 2011).

As indicated, the use of such models as a guide to empirical research has been questioned. Of major concern is the fact that both the trait model of occupational classification and the functionalist explanations of the role of professionals within society, fail to recognise the temporal and contextual nature of the concepts of professional and profession(s) (Freidson, 1994). Taking this into consideration, the trait model of identifying and classifying professions is reflected in the propositions shaping the research questions addressed in this thesis. The emotive nature of those characteristics associated with the term "profession" may contribute to the

identity individual professionals have (Herdman, 2001), or feel they should have (Carmel, 2006) i.e. their professionalism. However, to solely use such a model as a guide to empirical investigation would be, based on the criticisms levelled at this body of work, inappropriate (Evetts, 2011).

Professions as processes:

Taking a more interactionist perspective and mainly drawing on the work of Max Weber, a number of authors have proposed models suggesting that the attributes described by the trait approach and rationalised through functionalist writings, act primarily as a means of maintaining and legitimising the work of professionals. The characteristics often associated with professions serve only to protect their roles and maintain monopolies over certain areas of the labour market. Concepts such as the professional project (Larson, 1977), jurisdiction and conflict (Abbott, 1988) and social/market closure (Witz, 2003), have been used to describe how professionals seek first to establish themselves in the labour market and then maintain their privileged position. These more critical approaches to the sociology of the professions introduce the concept of competition and rivalry between professions as they strive to maintain and control their positions within the labour market (Abbott, 1988). As indicated, these models of professionalisation (a term emphasizing processes as opposed to functions), draw largely from an interactionist perspective, and demonstrate a shift from what professions are to what they do; this is significant in that it introduces the concept of social action, a clear example of this being Burrage et al., (1990, pp. 203-225,) who suggested that when studying the professions we should adopt 'an actor based framework'. From an empirical perspective, viewing professionalisation as a social process moves the focus of investigation toward a more exploratory as opposed to descriptive enterprise. In the professional project Larson (1977), focusing on the medical profession, extends the early work of Freidson (1970) by suggesting that through the development of specialist knowledge professions are able to justify and control their position within society. Larson's proposition, drawing on the work of Weber, is that through the development of specialised knowledge and collective action, professions place themselves in a position in which they can control access to this knowledge or at least be in a position which allows them to bargain with their patrons (e.g. the state,

employer or client) regarding access. Larson on the whole comments from a macro perspective generally omitting the content of professional activities over their form. Taking this into consideration, however, a number of authors have used Larson's work as a means of structuring empirical research (Edmunds and Calnan, 2001; MacDonald, 1984; 1995).

MacDonald (1995) champions Larson's work suggesting that it offers 'considerable analytical power' (MacDonald 1995, p. 34). Adapting the work of Larson, MacDonald (1995) suggested an analytical framework incorporating the notions of the professional project, but placing more emphasis on the role of the state, or more precisely the political culture, a key point raised by Johnson (1972). The battle for and maintenance (Witz, 2003) of, jurisdiction (Abbott, 1988) are also acknowledged by MacDonald. Finally and of significance from both a theoretical and empirical view is the importance placed on how individual professions see their roles. Extending Halliday's (1985) point that professions are not isolated groups with the sole aim of promoting their own agenda, consideration is given to the idea that professions and individual professionals have their client's interest at heart. It is made clear, however, that an emphasis on such traits as altruism and personal ethics is not a return to a trait model of identifying professional practice; rather such characteristics are essential in order for professions to persuade both their clients and their patrons of their unique place in society. MacDonald integrates the neo-Weberian perspectives developed by Larson and Abbott, but views them still as separate entities in his analysis; as a result he reinforces the concepts of closure, jurisdiction and the professional project without really advancing them. Again such a macro analytical perspective of professional work fails to acknowledge individuals and their often complex, contextually bound interrelationships. MacDonald clearly adds to the empirical foundations for investigating professionalisation, however his focus on the macro elements distracts from the local negotiations individual professionals are involved in, in their day-to-day work (Wenger, 1998).

Although not acknowledging Larson's work, Abbott (1988) builds on her basic propositions with regards to the idea of professions positioning themselves in the market. A key aspect of Abbott's work is the importance he places on the exclusivity of professional work leading him to suggest that:

the central phenomenon of professional life is the link between a profession and its work, a link I shall call jurisdiction. To analyse professional development is to analyse how this link is created in work, how it is anchored in formal and informal social structure and how the interplay of jurisdictional links between the professions determines the history of the individual professions themselves. (Abbott, 1988, p. 20)

Empirically, Abbott attempted to move from a micro perspective of observing what professionals do in practice, to the formulation of theory which he terms the system of the professions. In critiquing Abbott's work MacDonald (1995) has argued that although reflecting Weberian theory, Abbott fails to recognise this in his work. Although the move from micro to macro has been criticised, (Freidson, 1994), this focus on individuals and their day to day actions has allowed researchers to move beyond the more dominant sociological theories and explore professional practice from a more ethnographic perspective.

With regards to allied health professions, the work of Richard Hugman (1991) offers some useful insights into the professionalisation of the caring professions. Of importance in Hugman's analysis is the concept of care and its relationship to power. Due to the content of their work, Hugman distinguishes nursing, the allied health professions and social workers, as being fundamentally different from other professions, for example the medical or legal professions. Hugman acknowledges that all professions care about their work and in doing so accepts, to a degree, elements of the functionalist interpretations of professions. Extending this however, Hugman argues that in contrast to medicine who are seen as defining their work through rational scientific impartiality, nursing, the allied health professions and social work define their work through their relationship to patients. In addition to caring about their work, nurses, allied health professions and social workers, care for their patients (Hugman, 1991, p. 11). In their work as caring professions, nurses, allied health professionals and social workers adopt roles and carry out tasks which are more accessible to the general public and as a result are seen as less expert. The value placed on these tasks is thus diminished. In charting the professionalisation of the semi-professions, Hugman argues that the development (or lack of) of nursing, the allied health professions and social work as professions is

reflective of the power relations between professions and wider social processes of gender and race.

The notion of inter-professional competition and jurisdiction is one which has attracted considerable attention recently (Adams, 2004; Edmunds and Calnan, 2001; Borthwick, 2000). An example of this with regards to health care professionals can be found in the work of Adams (2004). Investigating the apparent conflict between dentists and dental hygienists in Canada, Adams (2004) draws on Larson's work in order to provide an empirical frame of reference for her analysis. Adams argues that, through aspects of governance and the ideology of marketisation, professionals are losing their bargaining power with both the state and the public, an assertion which has been put forward by a number of authors (Scourfield, 2006; Foster and Wilding, 2000 Ackroyd, 1996). Focusing specifically on allied health professions (Podiatry) and thus serving as a key author for this thesis is the work of Alan Borthwick. Borthwick (2000) utilised the concept of jurisdiction as a frame of reference in his research on the development of podiatric surgery in the UK. Adopting a qualitative methodology using primarily interviews, Borthwick describes the strategies employed by podiatrists in their attempts to gain jurisdiction over surgery in the foot and ankle, and those used by orthopaedic surgeons in their attempt to retain their jurisdiction. Interestingly, Borthwick suggests that changes in the way health services are being commissioned and provided, with more emphasis on primary care, allowed podiatrists to encroach on the work of orthopaedic surgeons. The interrelationship between professions and the influence of changes in healthcare policy has also been highlighted by Edmunds and Calnan (2001). Focusing on the interactions between pharmacists and GPs, Edmunds and Calnan (2001), investigated the possible reasons for pharmacists wanting to expand their jurisdiction with regards to dispensing medications and the resistance provided by GPs. Using a telephone interview based qualitative approach, the authors suggested that although the majority of pharmacists wished to extend their practice, they struggled with the concepts of entrepreneurialism and altruism, often seeing themselves as business people by the fact that they 'ran a shop'. The boundaries between the roles of GPs and pharmacists were reluctantly challenged by pharmacists, leading the authors to conclude that:

these findings seem to confirm the conclusions of other studies which suggest that pharmacists may themselves contribute to their lower status in relation to medicine because they are not sufficiently prepared to challenge the status quo. (Edmunds and Calnan, 2001, p 950)

From this snapshot of the literature it seems apparent that the local negotiations regarding professional jurisdiction and boundaries vary according to the professions involved and the contexts, in which they work, as well as the profession's perceived identity and status. Empirically, based on this interpretation, investigations into professional roles, boundaries and identities need to take account of the local negotiations and the contexts in which these occur.

The theories of professional practice and professionalisation already outlined draw heavily on the work of Max Weber. Weber argued that viewing professions merely as a subgroup of occupations neglects the distinctive attributes and activities professions engage with in order to establish and maintain their position within society.

What seems apparent from the sociological literature reviewed so far is that a key concept of the professions is the immeasurability of, and personal involvement in, their work. The concept of immeasurability has led a number of writers to question the role of professions in contemporary society where greater value is placed on choice, transparency and value for money (Hanlon 1998; Southon and Braithwaite, 1998).

The contextual and temporal nature of professionalism:

Alongside the Functionalist and post-Weberian theories of professional work, there has and continues to be a view that the terms "profession" and "professionalism" are socially constructed, contextually and temporally bound, and as such are open to negotiation. A number of authors such as Larson, in her later work (1990), Freidson (1994) and Wenger (1998), have placed individual professionals as the focus of their enquires into professions and professionalism. A focus on what professionals do at a micro interactive level is significant in that it has prompted a line of investigation which has placed the day-to-day actions of individuals at the heart of empirical

investigation (Allen, 2000). The adoption of more constructionist or phenomenological perspectives to the study of professions has allowed researchers to move beyond the macro theories of professions, which Friedson has argued, have as their focus occupations and the division of labour, as opposed to professionals themselves. The adoption of a broader analysis of professions, which draws on a number of sociological frames of reference not just the division of labour or occupations, has allowed sociologists to develop theories addressing professional practice which take account of the micro, individual elements of professionalism.

A focus on individual professionals and their work has prompted Freidson (1994) to suggest that any study of professions should primarily adopt a phenomenological approach. The term profession is viewed as a socially constructed concept and as a result, is used by a number of different social groups in different contexts and at different times, to mean different things. To view the term as being fixed is therefore inappropriate. Taking a more constructionist perspective Friedson (1994) views the concept of profession as something which is contextually and temporally bound, in addition to this it is a concept which is continually negotiated. Any empirical enquiry moving beyond this negotiation moves beyond the concept of profession to the broader field of occupations. Friedson places more emphasis on the concept of professionalisation than profession, stating that the process of professionalisation:

produces distinctive occupational identities and exclusionary market shelters which set each occupation apart from (and often in opposition to) the others. (Friedson, 1994, p. 16-17)

The formation of professional identities is of interest, with Freidson noting that this appears to be a particular idiosyncrasy of professions in the UK and US (when compared to Europe). Freidson draws attention to the socialisation processes through which members of professions pass, giving particular attention to the long periods of formal education normally associated with professions and the ways professional work is organised. It is through these processes individuals develop particular professional identities, which as Freidson suggests bring individuals within a particular profession to identify more with their profession than their employer:

Organised specialised occupational identities get constructed. Knowledge gets institutionalised as expertise. The structure of meanings and

commitments can override organisational goals and commitments. (Ibid, 1994, p.99)

Freidson echoes the work of Witz (2003) (market shelters) and Abbott (1988) (Jurisdiction); however, from an empirical point of view, he offers a direction which addresses one of the key criticisms of the more macro perspectives. Viewing the concept of profession as socially constructed allows one to move away from any overarching definition. Liberation from an ideal or fixed concept allows researchers to focus on the 'untidiness and inconsistency of the empirical phenomenon' (Freidson, 1994 p. 25). Any analysis, it is argued, should therefore focus on illuminating how groups and individuals negotiate their identities within a particular organisation. As Freidson suggests:

The strategy of analysis, therefore, is particular rather than general, studying occupations as individual empirical cases rather than as specimens of some more general fixed concept (1994, p. 26).

Freidson's arguments are convincing and have clearly influenced researchers working in the sociology of professions (Mackey, 2007; Carmel, 2006; Bligh, 2005; Ovetveit, 1985). Such a focus is not, however, without criticism, with MacDonald (1995) suggesting that by focusing on the micro perspectives of individuals, research fails to address the influence a particular group in society has over other groups at a more structural level. Analysis focusing solely on individuals without regard for the context in which they work (both physical and political), or reference to broader social theories of occupations would I agree be very narrow. Friedson makes it clear that any investigation at a micro level needs to acknowledge the context and build this into the mode of enquiry. Over all, Freidson argues for a bottom up approach to the study of the professions. This approach is reflected in a number of studies focusing on professional processes and professional identities, the majority adopting an ethnographic approach.

An important turn in the study of the professions was the development of negotiated order theory (Strauss, 1963). Emerging primarily within the sociology of medicine and reflecting core elements of symbolic interactionism, negotiated order theory provides an empirical and theoretical basis for the study of individuals within organisations, recognising both an individual's agency and the contexts or structures

within which they operate (Day and Day, 1977). Social order is continually formed and reformed through the active negotiation of social actors (Hughes, 1971). Focusing on social relations and the contexts in which these are formed, negotiated order theory has, and continues to be utilised in the study of the relationships within and between health care professions (Svensson, 1996; Allen, 2000; Germov, 2005; Nugus et al., 2010). In saying this however, it is not without its criticisms (Day and Day, 1977). Although conceived in part, as a reaction by social interactionism to the acknowledgement of both contexts and structures, negotiated order theory fails to provide a basis for the influence these elements may have on social action. As Day and Day argue:

There is an implied dialectical relationship in which the informal structure of the organisation acts upon the formal structure, producing change. (1977, p. 132)

The relationships between social action and social structures therefore remains obscured.

Reflecting on the literature reviewed in this section there appears to be three core elements with regard to the theoretical and empirical discussion of professionalism and professional practice; that any empirical investigation into the professions needs to take into consideration individuals, the processes in which individuals engage in order to enact their concept of professionalism and finally the micro and macro culture in which those individuals and processes are situated.

Structuration theory as a means of bridging the macro and the micro:

Although not contributing to the sociology of professions directly, the work of Anthony Giddens, in particular his theory of structuration, offers a useful, theoretical foundation from which to formulate an empirical approach, allowing the researcher to give equal attention to both macro (structural) and micro (agentic) elements in the construction of professions and professional work. Writing over a period of two decades Giddens has developed his theory of structuration as a means of addressing the ontological “gap” between structuralist approaches (for example functionalism) and interpretative approaches (for example phenomenology)

(Giddens, 1993, p. 4). Giddens conceptualises structure as a duality in that social structures shape the actions of agents which in turn influences social structures. Structure and agency therefore should not be seen as two separate elements constituting social action. Using Giddens' analogy, structure and agency are 'two sides of the same coin' (Giddens, 1984, p. 25). Fundamental to Giddens' theory is the notion that society is in a constant state of flux. Social actors draw on structures in order to form their actions and by doing so recast and reinterpret these social structures. Structures shape practice, but it is only through practice that structures are created and reproduced; social structures are processes as opposed to states (Sewell, 1992).

A number of ontological assumptions shape structuration theory. A fundamental proposition is that an individual's and collective's social action are structured based on a shared understanding of what constitutes social life, and through this process or praxis social structures are reinforced and reproduced. Individuals are not passive in the process however, through constant reflection upon social action both individuals and groups refine and modify their actions and as a result change social structures. This active reflection is captured in Giddens work through his emphasis on the knowledgeability of social actors, i.e. we know what we are doing. The shared knowledge or norms of social action are thus in a state of flux constantly being interpreted and refined through active reflection on the part of the individual or group. Similarly to negotiated order theory, Giddens places emphasis on the temporal and contextual nature of human action, this being reflected in the concept of contextuality or locales of interaction where set routines and patterns of interaction are created and maintained. In his analysis of social order and transformation, through structuration theory, Giddens highlights and forms relationships between key agentic and structural elements. Moving between agentic or interactional aspects, to more abstract rules and resources, or structures, Giddens identified and positioned modalities as the arena where the dialectical relationship between structure and agency intersect. Modalities thus represent the medium of interaction and structure (Giddens, 1993, p. 129). In his 1993 text, Giddens displays this relationship diagrammatically in the form of a table

Table 2.1 Structure-agency. (Taken from Giddens, 1993 p. 129)

Table 2-1 Structure-agency			
INTERACTION	communication	power	morality
MODALITY	Interpretive scheme	facility	norm
STRUCTURE	signification	domination	legitimation

Structures are divided into three coexistent categories; signification, domination and legitimation, each determining elements of social action, which when translated into agentic action are interpreted as communication, power and morality respectively. Of importance are the meanings attached to social actions within their context, something which Giddens captures within the modalities of interpretive scheme, facility and norms. Thus the modalities have utility in that they give meaning to day to day action, but in doing so permit the reinforcement and refinement of structure and agency,

Criticised as being too eclectic (Johnson et al., 1984; Cohen, 1998) and abstract (Gregson, 1989), Giddens' strongest opposition has been put forward by critical realists such as Margaret Archer (1982). Archer's principal argument is that in viewing structure and agency as so closely connected 'the constitutive components cannot be examined separately...in the absence of any degree of autonomy it becomes impossible to examine their interplay' (Archer, 1982 p. 77).

Although drawing on key social theorists, Giddens' work is presented in an abstract and philosophical way. In response, Sewell (1992) has taken the concept of structure and broken it down in a way which makes it more accessible to social researchers. In a similar fashion Emirbayer and Mische (1998) have, by drawing on the work of Giddens (among others), provided a detailed account of agency. Through these accounts of both structure and agency the often abstract work of Giddens has been translated into a format which lends itself to empirical work.

Hardcastle et al., (2005) have provided an overview of structuration, outlining key concepts embedded in the theory. In their review they place emphasis on the knowledgeability of agents in their utilisation of social structures, in order to influence their day-to-day. In relation to research into nursing practice, Hardcastle et al., (2005, p.231) make the claim that 'the theory provides a system for organising and categorising data that incorporates the social context of structure and agency from both micro and macro levels'. The ability to traverse between micro and macro is

strongly emphasised by Stones in his adaptation of structuration theory (2005). Through the application of structuration theory Stones argues that the often abstract philosophical concepts described by Giddens have utility with regards to empirical work.

There is a growing body of literature which draws on structuration theory as both an ontological and epistemological paradigm (Hardaker and Singh, 2011; Workman, 2010; Stones, 1991). Of particular significance in light of this thesis is the work of Hotho (2008). Drawing on structuration theory and social identity theory, Hotho investigated the relationship between professions and individuals with regards to the formation of professional identities in the hospital context. Although only based on data from a pilot study Hotho's work provides an example of the utility of structuration theory in the sociology of the professions and professional identity formation.

Power and professions:

One concept in particular, which has influenced sociological thinking around professional relationships, is power (Johnson, 1972; Scott, 2001). Although not always overtly stated (Freidson, 1970), attributes such as autonomy, and a high level of education and control of knowledge, place professions in a position within society of relative power. As a line of enquiry the concept of power as a specific aspect of the sociology of the professions is rarely made overt; however, one only has to glance at the models of professional practice proposed post-functionalism, to see that power is inherent. Abbott's (1988) notion of jurisdiction and inter-professional conflict, and Witz's (2003) work looking at professions in relation to the concept of patriarchy, are clear examples of where power forms a central concept. An exception to this is the work of Hugman (1991), who in his analysis of the caring professions places power at the centre of his arguments.

The concept of power within the sociological literature is contentious. Writers who have adopted a mainly Weberian stance with regards to professional practice on the whole appear to view power as the ability of groups within a society to secure access to and control over critical social resources (Poggi, 2006). In the case of professionals, examples of these resources would be knowledge and jurisdiction

over practice. Although influential this perception of power does not fully address the individual and individual interactions; nor does it take into consideration the points identified above, with regards to identity formation as an element of professionalisation. An alternative to the Weberian concept of power can be found in the writings of Michael Mann (1986) and his concept of ideological power. Mann suggests that individuals and social groups create cognitive and normative frameworks in order to structure and give meaning to their activities. More specifically, through these frameworks individuals are able to give meaning to their emotions and create and sustain their identities. Ideological power, therefore, 'emerges to the extent that a distinctive group establishes privileged control over the social activities and the cultural artefacts relating to the satisfaction of these needs' i.e. their emotions and identities (Poggi, 2006 p. 467). From this perspective power is inherently linked to the process of identity negotiation.

One of the earliest writers to address the issue of power and the professions was Terence Johnson. Johnson's work (1972) concerning professions and power, focused primarily on the relationships of occupations perceived to be professions, with the client. Key points of relevance stemming from Johnson's work are firstly the suggestion that through the development of a collegiate network, professionals are able to establish and control their power base. The more abstract professional knowledge the greater control a profession will have over their clients; and finally the role of the state in mediating between a profession and a client, the suggestion being that the greater the state mediation the less powerful the profession. Reflecting on these points in light of the marketisation of healthcare, it could be argued that through the introduction of patient centred practice and the greater freedoms offered to employers (through the formation of foundation trusts), professional practice and identity will become more diluted and contested (Baxter 2011). This final point is interesting, with Johnson suggesting that where the state mediates professional activities to the degree that professions become employees of larger organisations (such as the case in the NHS), professional knowledge becomes diluted and absorbed into the bureaucratic system. One consequence of this is that individual professionals may take on more divergent roles, depending on the organisation they are working in. As Johnson suggests 'differences in the structural or organisational location of practitioners are, then, likely to generate divergences of orientation; there

will be varying degrees of self-identification with the occupational community' (1972, p. 81). Of interest here is the use of the term self-identification, one of Johnson's key propositions being that professional power in part stems from their collegiate action. One criticism of Johnson's work is that although academically interesting, his arguments do not lend themselves directly to empirical enquiry (MacDonald, 1995). Although this may be the case, a shift in focus from professions to professionals themselves is significant and appears to be more evident within contemporary literature, with a number of authors focusing on the inter-professional dynamics and professional identity at a micro level.

Of growing interest in relation to the concept of power in the study of professions are the works of Michel Foucault and his theory of the relationships between knowledge and power. From a Foucaultian perspective, power is seen as having no 'substantive content', rather it is a 'technology' or technique employed by different groups or individuals within society (Lechte, 1994). Viewing power as a set of systems or techniques for control, places the focus of enquiry on to the 'channels through which power flows and the methods by which it is exercised' (Cohen, 2006, p.213). Closely linked to Foucault's conception of power is the concept of governmentality. Seen as an umbrella term for a set of practices, institutions and technologies, governmentality is a system through which political power can be exercised (Cohen, 2006). It is important to mention that, although the state is often regarded as the source of political power, the concept of governmentality is much broader, representing a capillary system through which powerful discourses can flow. Foucault's ideas are beginning to influence writers with regards to inter-professional relationships and professional identity (Mackey, 2007; Bondi, 2004; Manias and Street, 2001; Evetts, 2006)). Of particular interest is Foucault's 1973 work entitled "The Birth of the Clinic". Here Foucault suggests that the medical profession, via its control of the discourse of disease and through the creation of hospitals as arenas in which medicine is practised, has taken ownership and control of this most intimate aspect of human life. Through the control of knowledge and the creation of the hospital as an institution, medicine is able to employ the technology of power.

The work by Freidson (1977), although not directly referring to Foucault, reflects some of his arguments, in particular the suggestion that social groups exert power

over others through the creation and control of a powerful discourse. The power interplay between professional groups has been highlighted by Manias and Street (2001) in their study looking at the interplay regarding decision making between doctors and nurses in an ITU setting. Using an ethnographic approach, Manias and Street found that the discourse of nursing was dominated by the medical paradigm and concluded that medicine was able, through the use of knowledge, to maintain its position of relative power.

Larson (1990), in one of her later works, placing importance on context and taking a more constructionist perspective, focuses on how professions through the use of powerful discourse maintain and justify their position within society. Larson's main focus is on the relationship between knowledge and power, leading her to suggest that 'all professional or professionalising phenomena must be theoretically linked to the social production and certification of knowledge' (1990, p. 25). As a concept, knowledge is not new within the sociology of the professions, however, here Larson is placing the production of knowledge at centre stage and offering a paradigm from which it can be analysed empirically. Drawing on both the works of Foucault and Bourdieu, Larson argues that professional practice is controlled by institutional domains (for example professional bodies, universities or hospitals), which create and disseminate authoritative practice. Larson suggests that there is a core from which authoritative discourses originate, this being researchers in the case of professions. This core is surrounded by those trusted with the training of those wishing to join the profession. Larson acknowledges that employers of professionals will influence their discourse, as will the context in which they work. At the periphery are the individual practitioners who, dealing with the lay members of society, are having to adapt and interpret the authoritative discourses, and it is here that any focus on discourse should begin, for as Larson suggests it is at this point that different "truths", different discourses are brought to bear upon codes of practice for which practitioners tend to invite, as their foundation, the "true" discourse produced at the core' (1990, p. 38). An interpretation of Larson's model of the creation of discourse is that through the control of knowledge production and the physical link between those tasked with creating the core knowledge and those tasked with passing it on, professions are able to socialise their members into the adoption of truth. As Larson argues, 'the control of knowledge always ultimately depends on

controlling the subjects who know' (1990, p. 32). When challenged, it is the truth produced at the core which is used to defend practice, as this is seen as the most powerful. A number of the propositions put forward in Larson's later work have not been tested empirically and are therefore open to interpretation. The idea that knowledge is controlled by institutional domains fails to recognise the concepts of inter-professional negotiation and the importance of the client with regards to professional practice as outlined above. In addition to this, Larson's focus on the source of authoritative discourse neglects somewhat the concept of governmentality and the flow of power. There has, however, been some empirical work which suggests that through the processes of professionalisation, professionals are socialised to accept a particular version of the truth. Apker and Eggly (2004), adopting a qualitative methodology based on observations, focused on the discourse of medical staff during "morning report"; a purely doctor to doctor interaction. Their findings suggest and support Larson's proposition that through discourse, doctors reinforce a particular ideology (in this case a scientific model of medical practice), this in turn leads to the creation of a distinct professional identity.

As indicated Larson draws heavily on the work of Foucault suggesting that any empirical analysis of professions should focus on the various discourses employed. From an empirical perspective Foucault's works offer an interesting alternative to the largely interactionist lines of enquiry which dominate the sociology of the professions. The conceptualisation of power as a technique, as opposed to a substantive concept, shifts the focus of enquiry onto the activities and interconnections individuals and groups engage in in their everyday lives. In contrast to the Weberian perspective, where the focus is more inclined towards the asymmetry of power, Foucault's concept views power more neutrally. In addition to this Foucault suggests that through the concept of governmentality, power flows across society and infuses social life to the degree that the most powerful discourse is accepted as the norm. Taking Mann's concept of ideological power Foucault offers a means of investigating the processes through which an individual's or group's frame of reference is shaped.

Extending the focus on discourse and the analysis of power in relation to professions, Evetts (2006) has argued that the concept of professionalism is now being seen as a complex form of organising occupational roles which at the same

time serve to promote and provide a civic responsibility away from the more rigid Weberian concepts of bureaucracy. Crucially in Evetts analysis, is the notion that control emerges from within professions and is exerted upon professions, the former being evidenced by professions claims to knowledge and collegial authority, the latter in the emergence of systems of governance and managerial control. The merger of these two discourses being seen as a means of gaining legitimacy within organisations and social institutions.

Although serving as a useful referent for critical evaluations of professional practice (Manias and Street, 2001,) Scott (2001) had pointed out that in his writings Foucault gave little attention to the nature of expert power (ibid, p. 100). In addition to this, in critiquing Foucault's work there appears to be little scope for agentic action on the part of individuals who through systems of governmentality appear to accept unquestioningly the dominant norm as determined by elites (Scott, 2001). Foucault leaves little space for negotiation (Nugus et al., 2010). In contrast Giddens' conceptualisation of power as transformative capacity opens the concept up, acknowledging the contextual and temporal elements embedded within (Giddens 1993).

Professional identity:

A key element in the research questions addressed in this thesis is identity. A focus on individuals within the wider field of investigation into professionalism has led a number of writers to begin to consider the notion of professional identity. The focus on identity has taken two very broad approaches, although there are arguments which suggest that the two fields overlap considerably (Cote and Schwartz, 2002), these being a psychological perspective and a sociological perspective. Taking the concept of profession and interpreting it as an element of the broader concept of identity, has allowed researchers to span the spectrum of individual to collective/institutional process and action in order to interpret professional action in contemporary society (Baxter, 2011).

Psychology has a long tradition of focusing on identity and identity formation (Weinreich and Saunderson, 2002). At a very simplistic level, identity, from a psychological perspective, can be defined as ‘the internal, subjective concept of oneself as an individual’ (Reber, 1985, p.341). In general, most psychological theories of identity focus on its formation, viewing it as a maturation process over the course of an individual’s life (Cote, and Schwartz, 2002). A criticism of the psychological “statuses”² of identity formation is that they fail to take into consideration broader social-contextual elements which contribute to the development of one’s identity (Cote and Levine, 1988). In response to this criticism the more psycho-structural theories of identity, for example “othering”, suggest that we define our identities by indicating what we are not (Ashforth and Mael, 1989). Marking differences as opposed to similarities allows us to situate ourselves and our identities in a more fluid and open way (Shapiro, 2008).

Social identity theory (Tajfel, 1992) has been used by a number of researchers to interpret the processes via which individuals and groups form identities. Davis (2002) has suggested that the creation of a professional identity, through the process of othering³ has created an identity which is emotionally detached, neutral and somehow apart from ‘ordinary people’. Taking binary thinking as a frame of reference, Davis argues that by setting themselves apart from others, professionals could be dismissing core elements of their identities for example emotional involvement and doubt, which are equally as important in the delivery of health care services.

Utilising critical discursive psychology as an analytical frame of reference, Reynolds (2007) investigated how professionals use different discourses when working in the multi-professional setting. In her analysis Reynolds comments on how, through the process of othering, individuals create barriers to inter-professional working. In addition to this, however, Reynold’s suggests that the rigid binary divisions identified by Davis (2002), for example doctor patient, qualified and unqualified, have been diluted by the introduction and emphasis on inter-professional working. One potential

² Referring to the identity status paradigm (Marcia, 1966) which proposes that identity formation occurs as a process of maturation. Four identifiable periods or statuses form a hierarchical typology of self regulation and social functioning. (Marcia, J. E. (1966) ‘development and validation of ego identity status’. *Journal of Personal and Social Psychology*, 5, pp. 551-558

³ Defining self through differentiation from others

outcome of this is greater inter-professional collaboration. Although not indicated in her study, the work by Reynolds offers some theoretical explanation away from the more dominant post Weberian perspectives, as to why inter-professional teams face difficulties. More recently Kreindler et al., (2012) used a social identity approach as a theoretical lens through which to analyse research papers focusing on professional identity. They concluded that through the creation of profession specific identities, professions create “silos” which could be used to either block or facilitate changes in working patterns. Overall, Kreindler et al., (2012) argued, that although useful, research which focuses primarily on identity from a psychological perspective neglects broader social interactions.

As indicated, although psychological theories of identity can provide some explanations as to how and why professionals function, they have been criticised heavily for being too deterministic, “intrapsychic”⁴, often neglecting the broader social and contextual factors which go into shaping one’s identity (Baxter, 2011; Cote and Schwartz, 2002). In contrast sociological theories of identity adopt the stance that identity and identity formation is an active process. ‘Identifying ourselves or others is about meaning, and meaning always involves interaction: agreement and disagreement, convention and innovation, communication and negotiation’ (Jenkins, 2004, p.4). A sociological stance on identity places emphasis on the contextual and temporal elements of identity and identity formation. The concept of individualisation, drawing on the work of Beck (1992) for example, suggests that individuals have greater flexibility in the formation of their identities, this formation being both contextual and temporal and crucially negotiated as opposed to fixed. As indicated, sociologists have tended to focus their attention on groups as opposed to individuals with regards to identity and as such, identity as a concept is regarded as something which is created through interactions and institutions. Identity is a process as opposed to a thing. Jenkins, pulling together some of the key themes concerning the sociological stance on identity (2004) has suggested that identity can be best understood as three distinct orders namely the individual, interaction and institutional order; the individual order of identity is, put simply, what goes on in an individual’s head, the interaction order is concerned with the relationships between individuals,

⁴ Referring to internal psychological processes

and finally the institutional order is 'the human world of pattern and organisation, of established ways of doing things' (Jenkins, 2004 p. 17). Of importance is the acknowledgement which Jenkins (p. 18) makes when he states that 'it is almost impossible to talk about one without at least implying the others'.

There is a clear overlap with Jenkins's taxonomy and the terms "professionalism" and "professionalism", with professionalism concerning itself with the internal representation of professional identity, and professionalism corresponding with the interaction and institutional orders, i.e. the culture of professional practice. Baxter (2011) in her review of the literature on public sector professions, has suggested that the term professionalism refers more to the external control mechanisms associated with professions, for example regulation, whereas in contrast professionalism is more reflective of the agentic elements of a professional's work, this being more indicative of their 'salient professional identity' (p. 33).

Expanding on the final two elements of Jenkins taxonomy, namely the interactional and institutional orders, Jenkins argues that through our interactions with others, we construct our identities and they are to some degree constructed for us, the process being one of perpetual change and negotiation, for example through the processes of labelling (Goffman, 2009), group identification (Barth, 1969) and categorisation (Tajfel, 1992). In addition to this the institutional element of the identification process creates the notion of identity as something which exists externally to an embodied individual (in contrast to the arguments presented regarding professionalism).

Institutions, from a sociological perspective, can be regarded as either concrete social forms for example the family or the Church (Turner, 2006), or more subtle 'patterns of behaviour that are regulated by norms and sanctions into which individuals are socialised. Institutions are an ensemble of social roles' (Turner, 2006 p. 301). Institutions give a normative reference point as to how things should be done (or not) and thus involve control (Jenkins, 2004 p. 135). Referring back to the work of Giddens (1984) and Sewell (1992), social structures, for example institutions and organisations provide social actors with rules and resources through which they can give meaning to their actions and identities. Of importance however, is the recognition of the reciprocal relationship between agents and structures. This duality is captured with regards to identity in the interpretations offered by Barth (1969), Berger and Luckmann (1991), Wenger (1998) and Cohen (2002).

Summary:

What has emerged from engagement with the literature regarding the sociology of professions, identity and social roles, is that the term professional is contextually bound, fluid and negotiated. The construction and actualisation of professions and professionals are bound within the wider social and political spheres of individuals and groups. What appears to have been brought into question with regards to the empirical investigation of professions, is the relationship between institutions and the individual. As a consequence empirical studies focusing on professions, professional identity and roles have drawn on a number of theoretical fields in order to ground their work and provide a framework for meaningful analysis.

A number of studies have investigated professional identity by drawing on psychological theories. Such theories, however, have been criticised due to their lack of consideration of the context. Taking the stance that identity is something which can be regarded as both individually and socially mediated has led sociological studies into professional identity to adopt broadly phenomenological or ethnographic approaches.

Professions and professional practice have been framed by focusing either through reference to abstracted sociological theories of work and occupations (Scholes, 2008; Mazhindu, 2003; Hoyle and John, 1995) or on the individuals themselves (Allen, 2000; Freidson, 1994; Abbott, 1988). Acknowledging that this is a very broad and blunt taxonomy, both approaches are not without criticism. Empirically this presents any researcher with a problem of reconciling the move from macro theories of professions and professional practice to micro perspectives or vice versa, whilst acknowledging that the two cannot be divorced from one another (Abbott, 1993). This relationship can be interpreted using Giddens' concept of structuration (Giddens 1993). Through structuration theory Giddens offers a theoretical model to link the individual and the collective to the contexts in which they operate. Structuration theory offers an empirical frame of reference which permits the illumination of the complex relationships between individuals, institutions and the organisations in which they interact.

Chapter 3

Health Policy and the Health Care Professions:

Building on the previous chapter it is clear that the context of professional practice plays an important role in shaping roles, boundaries and identities. The primary purpose of this chapter is to provide both the political and empirical context in which the research questions were formed and are framed. The chapter is divided into two sections. The first section provides a critical overview of health care policy, focusing specifically on the introduction of the internal market into the NHS, a policy trajectory which has resulted in a number of changes in how healthcare professionals work. Beginning with the changes introduced by the Conservative Government in 1989, the chapter goes on to describe and critique the trajectory of change pursued by New Labour and the current Coalition Government. The second section of the chapter reviews the empirical literature concerning how changes in the way health care services are organised have affected the work of healthcare professionals generally, and allied health professionals specifically. Overall the chapter serves to further detail the rationale for the research questions and propositions as well as provide the macro political context against which the case studies were analysed.

The initial literature search involved the use of the following bibliographic data bases, Social Care Institute for Excellence, Science Direct, and Psycinfo and CINAHL Plus via Ebsco. The key words included professionalism, professions, team work, policy reforms, allied health professionals, with Boolean operators (and, or) used as appropriate. Both Government and research literature was considered. Literature which had as its focus children's services, social work, education or mental health was ruled out at this stage. The decision to limit the scope of the literature accessed was based on the focus of the research questions developed in this thesis. The search strategy was supplemented by hand searching which involved the inspection of citations. Literature was reviewed conceptually and methodologically and considered for inclusion based on relevance to the research questions.

Conservative neoliberalism (1989-1997)

In 1989 the Conservative Government produced a White Paper which laid the foundations for the (then) most radical shift in NHS policy since its conception (Mays et al., 2000). The proposals laid out in the 1989 White Paper were developed without the involvement of the medical and paramedical professions, a first in the history of the NHS (Rivett, 1998). Working for patients (DoH, 1989) set out to provide an NHS which was responsive, flexible and cost effective. Through this policy and subsequent legislation, competition was introduced into the NHS in the form of the internal market. In line with New Right policy and the growth of advanced capitalism (May and Buck, 1998) State run organisations were viewed as monopolies (Minford, 1991). A lack of competition led to organisations like the NHS being accused of wastefulness and being unresponsive to consumer demands. As highlighted by Foster and Wilding (2000, p. 144) 'the charge from the New Right was that professionally dominated services like the NHS were always unresponsive to patients, because there were no built-in incentives to put clients first'.

The internal market split the NHS into two; on one side purchasers of services (health authorities and some GPs) and on the other providers of services (acute hospitals, community services and ambulance services or the private sector). Providers were given greater freedom both financially and managerially and given the title of NHS trusts. NHS trusts were required to compete against each other in order to win the contracts offered by the purchasers. The aim of the internal market was to provide choice, hence market competition, the intended outcome being greater efficiency and quality (Ham and Maynard, 1994). This radical shift in policy was supported ideologically by the neo-liberal trust in market forces. It was argued that one of the driving forces behind the internal market was the ever increasing cost of the NHS (Glennister, 1998). By 1995 all health care was provided by NHS trusts, care being purchased by either the local health authorities or by GPs who, similarly to NHS trusts, had greater managerial and budgetary responsibilities (GP fund holders). There were also greater incentives for services to be moved from the secondary care sector into primary care, this being facilitated greatly by the increased spending power of GPs.

The marketisation of the NHS led to a number of significant changes to how health services were delivered. A management culture was introduced into the NHS with greater bureaucratic control and surveillance over how professionals worked (Ham, 2004). Prior to the introduction of the internal market the NHS had been, on the whole, managed by health professionals, specialists in terms of medical and or patient care. This changed with the development of the health service managers' role. Responsible not only for budgetary decisions, health service managers were more active in resource allocation, service planning and decision making and staff development (Worthington, 2004). Reforms in the way hospitals were organised led to services being divided into identifiable units which were contained both managerially and financially (Ham et al., 1990). The dominance of medicine was evident in the division of services in that they were often structured around medical specialities. Of importance was that due to their small numbers the allied health professions often fitted⁵ into services as opposed to being seen as single professionally identifiable services in their own right. Hospitals were required to provide statistics on performance allowing purchasers the opportunity to make a choice about who they would commission services from (Klein, 2010), and patients, being more informed, could choose where they had certain treatments. Concerns regarding the introduction of marketisation, greater surveillance and the possibility of non-profession specific managers were voiced by both the CSP and COT (CSP/COT Joint Statement, 1992). A focus on costs meant greater scrutiny of services leading to the introduction of an audit and target culture into the NHS. Within the internal market health care was coming to be seen as a commodity, with patients the consumers (Kirkup and Donaldson, 1994). The Conservative Government under John Major⁶ introduced the term "patient centred practice" into the NHS. Patient centeredness, as a concept, has a number of interpretations (Cronin, 2004) however, in the context of health service organisation in the mid-1990s, patient centeredness meant that the resources followed the patient; the impression being the patient had the spending power. In addition to this was the aspiration that services would be structured around the needs of patients as opposed to solely being based on the recommendations of professionals. The arrival of the market

⁵ There were and continue to be notable exceptions to this for example podiatry (see Hayes 2013)

⁶ Leader of the conservative party 1992-1995

implied that there would be consumer choice; however, it is questionable if this actually occurred (Keaney, 1999).

The introduction of the internal market into the UK health system was discussed extensively in relation to the medical and nursing professions, however, empirical research focusing specifically on allied health professions is sparse. One notable exception is the work of Rosalie Boyce (1993), Based on a multi-country field work study which involved Canada, the UK, the US, Sweden and Australia. Boyce (1993) concluded that the introduction of an internal market into healthcare services privileged the medical and nursing professions over allied health professionals. The latter were not in a position to capitalise on marketisation due to their heterogeneous composition and their objective congruency into the focus of healthcare delivery.

Allied health professionals are vulnerable in a deregulated environment because they have not aggressively marketed and institutionalised an understanding of the contribution they are able to make to patient welfare in an outcome-based framework. (Boyce, 1993 p.212)

New Labour:

During its 13 years in government New Labour's intention had been to modernise the NHS, valuing innovation and individualism. New Labour indicated throughout its 1997 and 1998 White Papers that staff should be empowered to deliver services tailored to local need. What occurred, however, was an increase in external edicts determining not only how services should be provided, but also what services and by whom). This was exemplified in the 2006 White Paper ('Our health, our care, our say') with cost effectiveness, evidence based practice, competition, and rewards and sanctions being evident in how new services were to be developed and controlled. It is difficult to establish, based on the literature included in this review, the contribution of allied health professionals in the development of how services were organised. What is clear when reviewing the policy changes New Labour implemented in the NHS during its time in government was that the concepts of marketisation and governance remained central. Initially New Labour sought to abolish the internal market, replacing it with a system of co-operation as opposed to competition (DoH, 1997, p. 10). One of the first aspects of the marketization of the healthcare, GP

fundholding was abolished in 1997. New Labour accused the internal market of undermining the public service ethos of the NHS (Mays et al., 2000), arguing that the focus should be on the quality of care as opposed to the quantity. Accused of leading to a fragmentation of the NHS, increased bureaucratic costs and inequalities both regionally and nationally, the internal market was to be replaced. Proposed was a system where health authorities and primary care providers maintained the commissioning responsibilities for services (although these responsibilities would eventually be the sole remit of newly developed Primary Care Trusts, PCT) and that local NHS trusts maintained the remit of principal providers of services (Dixon and Mays, 1997). The relationship between the purchasers and providers was to remain in the format of a contract, however these contracts were to be longer in duration than under the Conservative Government (up to five years as opposed to yearly, allowing for greater stability) and based on strategic locally agreed health improvement programmes which took account of both national standards for health and local priorities. Of importance for allied health professions was that the contracts were based on whole packages of care rather than on individual elements of the package.

The White Papers produced by New Labour in its first term (1997; 1998) had talked about partnership and co-operation for the delivery of health services, but on the whole had remained uncommitted as to who would be co-operating and where partnerships would be made. The White Paper, The 'NHS Plan: A Plan for Reform, A Plan for Investment' (DoH, 2000) made it clear that New Labour was committed to the ideology of the market and, furthermore, the need for private investment. 'For the first time the NHS and the private sector will work more closely together not just to build new hospitals but to provide NHS patients with the operations they need.' (DoH, 2000, p. 15.) Described as a concordat, New Labour proposed private involvement in both the development of NHS facilities (Private Finance Initiatives), and in the delivery of services from cleaning and catering, telephones and televisions to operations. The NHS needed to be 'modernised' and the private sector was used as an appropriate model.

Modelling health care on the private sector was expanded radically in 2002 with the introduction of foundation trust status for some hospitals. Although all hospitals were now independent trusts, the degree of autonomy they exercised with regards to

budgetary freedom was limited. By gaining foundation trust status hospitals had greater freedoms with regards to how they managed themselves, for example they could sell off assets, subcontract services out or borrow money on the private market (Newbold, 2005). Although initially against the idea that GPs should be involved in commissioning services, in 2004 New Labour reintroduced a role in commissioning for GPs in the form of practice-based-commissioning. In addition, in 2008 New Labour introduced the option for some health care providers to become social enterprises. Defined as social businesses, social enterprise organisations operate to offer social products with a private sector approach (Miller et al., 2013). Greater financial independence for health care providers was accompanied by the introduction of payment by results, a system where health service providers would only receive income based on the quality of the service they provided (Klein, 2010).

By adopting a system of performance-related benefits or sanctions, and the introduction of private health care (monitored under national standards) New Labour intended to drive quality through competition. This was seen at the time as ‘an unprecedented shift for the Labour Government’ (Times, 2000 p. 17). When it first came to power New Labour sought to forge partnerships with a number of agencies, including professionals (Poole 2000), however as Newman (2006, p. 85) suggests ‘although key individuals were involved in task forces and policy discussions, the government tended to talk over the heads of the professions to win the support of the public and political stakeholder. Professional knowledge was set against the common sense of the public’.

A consequence of the processes of marketisation was the need for greater controls over the quality of services. It is important to note here that although a market system had been established in the NHS it was, and remains, a quasi-market in that some control of the content and quality of the services provided remains external to market forces (in principle). In order to proceed with its agenda of modernisation of the NHS, New Labour changed the way the state controlled and determined practices in the public sector. The concept of governance, introduced across New Labour’s reforms, was highlighted in the 1997 NHS White Paper under the heading “Clinical Governance”. In the more general sense governance can be seen as the state co-ordinating social activities as opposed to centrally controlling them. The state no longer holds all the resources required to govern; rather its role is to

empower and co-ordinate a range of institutions and actors both within government and external to it in order to bring about social change (Newman, 2006). The dissection of the NHS into consumers, providers and purchasers is reflective of this more general view of governance.

In the context of the NHS this decentralisation of power was seen as a key element for the delivery of truly patient centred services. In a similar fashion to the previous conservative government, in the context of health policy, patient centeredness was closely aligned to the notion of a patient as a consumer, in that they are able to make informed choices regarding their health care. The decentralisation of power from central bodies to individual trusts first proposed in 1997 was developed throughout New Labour's time in Government. The argument at the time was that a centralist approach to service management allowed less room for service innovation or appropriate local variations in care; a centralist approach being too prescriptive (Atkinson et al., 2000; Goodwin, 2002). New Labour set out a scheme for national standards of care to be developed, implemented and monitored, and a means of implementing policy at a local level (Newman 2006).

The National Institute for Health and Clinical Excellence (NICE) was created in 1999, its aim at the time was to provide 'a strong lead on clinical and cost effectiveness' (DoH, 1997). This, in conjunction with evidence-based National Service Frameworks (NSF) developed for specific client groups, offered national standards of care and cost effectiveness which guided the local health improvement programmes. Evidence-based practice (EBP), a concept first developed in Canada in the late 1980s, has grown in popularity in the UK. Choices about treatments based on the best evidence are now seen as fundamental by both managers and clinicians (Sackett et al., 1996). The clinical and financial practices of trusts were monitored and regulated by the Care Quality Commission (formally the Health Care Commission). With the Introduction of foundation trusts in 2002, the role of assessing the performance of individual trusts was split. The Care Quality Commission focused solely on clinical quality and a new independent regulator termed Monitor was put in place to regulate and assess financial performance (Klein, 2010).

These three providers of guidance were tasked with the role of driving the quality and efficiency of clinical practice at a national level and ensuring they were delivered at the local level. As well as ensuring local implementation New Labour built on an already established culture of audit within the NHS, extending the remit of audit to look at clinical as well as financial aspects of patient care.

The changes introduced by New Labour have had, over time, a profound effect on the allied health professions. Reflecting back on the observation by Boyce (1993) that when marketisation was first introduced into health care allied health professions were poorly prepared, its continuation has resulted in allied health professionals adopting strategies and discourses designed to demonstrate and evaluate their services in line with both national and regional priorities. Through the adoption of cultures of audit and evidence based practice allied health professions now try and demonstrate their contribution to patient care (Metcalf et al., 2001). A key question however is as professions, are allied health professionals evidencing their contribution to healthcare or merely how they fit into services structured by medicine and nursing?

Enter the coalition:

The following critique provides a contemporary account of the reforms introduced by the Coalition Government. The review spans the time period from the publication of the Coalition Government's White Paper (July 2010), up to the completion of data collection for the research in this thesis, a time which coincidentally coincided with the passing of the health and social care bill. It is acknowledged that due to the rate of reform and change, a number of the points discussed may well have been superseded.

In 2010 the Coalition Government produced⁷ its White Paper for health care in England. "Equity and excellence: Liberating the NHS" (DoH 2010). This set out a series of reforms which, after extended consultation and revisions, are beginning to take effect. The policy has been heavily criticised by many as a radical and aggressive marketisation of the NHS (Roland and Rosen, 2011), which is surprising

⁷ In the 2010 general election the conservative government was unable to form a majority and therefore formed a coalition government with the liberal democrat party

as very little has changed with regards to the overall trajectory of healthcare policy described above (Asthana, 2011; Light and Connor, 2011; Black 2010). Patient choice, decentralisation of powers, increased independent monitoring and the continuation of marketisation remain at the heart of the Coalitions' reforms. The White Paper recognises and values the work of previous governments, its primary criticism being that until now change has been too slow. In an attempt to combat the perception of inertia within the NHS the Coalition proposed a time line for change which has been the basis for much of the criticisms surrounding the White Paper (Walsh and Ham, 2011). In addition to this the changes introduced come at a time of previously unseen austerity, where public sector budget cuts have been harsh. Through the delivery of the changes set out in Liberating the NHS and subsequent policy documents it is clear that 'many in the NHS will feel threatened- organisations will disappear, jobs will go, clinical performances scrutinised, new competitors encouraged and power shifted' (Tribal, no date, p. 3). For some allied health professionals these concerns have become a reality with posts being frozen or, down-graded.

Patients, again, are seen as being at the heart of the NHS. This principle is underlined by the phrase "no decision about me without me" echoed throughout the paper (DoH, 2010, p. 3). The coalition envisages patients as true consumers. It is suggested that through making informed decisions patients will be in a position to drive changes in the NHS which reflect their needs. In order to do this, patients need to be provided with detailed information concerning the type and quality of services available. Reflecting on the interpretations provided previously the question arises as to the involvement of allied health professions in the development of services and thus the choices offered to patients. Underlining the need for informed patients, the White Paper proposed that all service providers (including GPs) be contractually obliged to collect and publish clinical outcome data. At the time of writing the focus of these outcomes was unclear; however, it would not be unexpected for them to have a primarily medical or resource focus.

It is worth noting here a shift in approach to assessing the quality of services. Under New Labour emphasis was placed on processes of care and targets as opposed to outcome. The shift to outcomes as opposed to processes or targets has been questioned by some, as there is little evidence to suggest that either system provides

a true reflection of quality (Roland and Ranson, 2011). At first glance the Coalition appears to be suggesting that outcomes (including patient reported outcome measures) be the primary indicator of quality. However, in describing the role of NICE in developing these outcomes there is a suggestion that process is just as important. Health outcomes will be 'authoritative standards setting out each part of the patient pathway, and indicators for the next step' (DoH, 2010, p. 23).

The incorporation of evidenced based standards of practice remains, as do the associated financial sanctions and rewards (DoH, 2010). The process of decentralisation of power from central government has continued (Pollock and Price, 2011). Power for deciding what and where health services are to be delivered is now shared between patients, local authorities and clinical commissioning groups (CCGs), formed and led by GPs. The White Paper introduces the concept of "demarcating legitimacy", which although not defined, is translated throughout the policy as strengthening choice for patients and commissioners. Patients, through access to detailed information on quality and performance, will be able to exercise choice as to who delivers and where they receive treatments. The responsibility for commissioning services has been transferred to CCGs and local authorities. The significance of this lies in the proximity and degree of control patients have over these two organisations (Roland and Ransen, 2011). In effect the Secretary for State will have very little control over the day-to-day delivery of health services; she/he will primarily influence health care through a newly formed autonomous body known as the NHS Commissioning Board, whose responsibility will be to ensure that commissioners reflect the national outcomes developed by itself and NICE. Patients have choice over where and when they receive treatments but not what they receive. The decision as to what services will be provided lies with the NHS Commissioning Board, through its endorsement of outcomes developed by NICE, CCGs and local authorities. As Tribal (no date, p. 5-6) have pointed out, 'If patients are to be empowered and to have real choice why shouldn't they have a say as to who commissions their health care? If parents can set up schools, why can't patients set up their own commission groups?'

Greater choice for health care providers is reflected in the government's vision of turning the NHS into 'the largest social enterprise sector in the world' (DoH, 2010, p.5). Building on examples like the Central Surrey Health social enterprise scheme

set up in 2006 (<http://www.cshsurrey.co.uk>), the coalition has put in place a policy which provides greater freedoms for providers of health care to decide how they are run. By 2013/14 all NHS Trusts have to have achieved foundation status. In order to be awarded foundation status Trusts will have to meet defined fiscal and governance requirements, a task that not all Trusts may be in a position to do. The White Paper made it quite clear that any Trust failing to reach foundation status by the deadline would be put into administration. One consequence of this so far has been that a number of Trusts have merged in order to achieve foundation status (Roland and Ransen, 2011).

In addition to making all NHS providers independent, the Coalition has opened up the market for the provision of health care through the introduction of any qualified provider (formerly any willing provider). In essence any provider of health care which meets the requirements of the Care Quality Commission regarding standards of service provision will be in a position to bid for contracts commissioned by CCGs or local authorities. The driving principle of competition introduced in 1989 and developed by New Labour therefore remains. Central to the continued competition within the delivery of services are the methods of payment. The White Paper makes it clear that 'the absence of an efficient payment system in many parts of the NHS severely restricts the ability of commissioners and providers to improve outcomes, increase efficiency and improve patient choice' (DoH, 2010, p. 24). In order to strengthen payment for services, the White Paper has continued with the concept of payment by results introduced by New Labour. Providers of services will be paid based on their achievement of specific health outcomes, determined nationally and locally. Of importance with regards to payment is the cost of services. Tariffs for packages of care will be set nationally by Monitor, however the ability to provide services based on these tariffs may mean that some Trusts have to streamline or specialise in what they do in order to remain competitive. In light of the changes introduced to both commissioner and provider roles, Light and Connor (2011, p.822) have suggested that overall the changes introduced in the White Paper are simply a 'recipe for a privatised NHS'.

As already indicated responsibility for commissioning has been shifted from Primary Care Trusts to CCGs and local authorities. Primary Care Trusts will be dissolved and replaced by groups of GPs initially organised in the form of consortia, however, after

extensive resistance, debate and delay (NHS Future Forum, 2011) consortia were replaced by smaller and more geographically limited groups known as clinical commissioning groups (CCGs) . Clinical commissioning groups will be responsible for commissioning all health care for their local population. The extra responsibility placed on GPs has not been welcomed by the British Medical Association, who argued that it would shift their members' focus away from patient contact and more toward managerial roles (BMA 2010). Although structured around GP practices, commissioning decisions made by CCGs should reflect the views of all professionals involved in the delivery of primary care services (for example nurses, allied health professionals and care professionals). The extent to which joint decision making beyond GPs is questionable (Checkland et al., 2012). Black (2010) supports the move suggesting that financial responsibility and clinical responsibility should go hand in hand; GPs are the ones facing patients every day. A number of authors have raised concerns regarding the new role GPs will play in commissioning services. Initially under the new reforms GP practice boundaries were to be abolished, therefore potentially allowing patients to choose their commissioner and possibly the commissioners to choose their patients. If the latter occurred, 'practices and consortiums will be able to compete (and advertise) for patients from across the whole country just as private healthcare corporations and health insurers do now' (Pollock and Price, 2011, p. 801). Although restricted geographically the establishment of clinical commissioning groups and the degree of choice now embedded in the system could create a "post code lottery" with regards to which services are available to patients (Black, 2010; Whitehead et al., 2010).

Commissioning for public health and health promotion services will be the responsibility of health and wellbeing boards established within local authorities. These boards are tasked with co-ordinating and developing strategic services for adult and children's social care. In contrast to GPs local authorities do have geographical boundaries and therefore are in a position to offer some stability and consistency with regards to services available to local populations. However, it is anticipated that the types of services commissioned and provided by local authorities will focus primarily on health promotion and prevention not health care. This has prompted Pollock and Price (2011, p. 801) to suggest that 'healthcare services, that consortiums and market providers deem will threaten their financial viability, can be

transferred out of the NHS in much the same way as long term care and continuing care responsibilities were transferred out'. Local authorities may become the provider of last resort, picking up services that are unpopular clinically or financially. The government expects both groups of commissioners to work closely together in order to provide integrated 'joined up' services (DoH, 2010, p. 4). Following on from previous White Papers Liberating the NHS places emphasis on the development of primary care services. Both local authorities and clinical commissioning groups have been tasked with preventing unnecessary hospital admissions by commissioning services which focus on treatments in the community setting or the patient's own home. Again this has come under heavy criticism. It is likely that with the introduction of plethora of providers the task of planning and co-ordinating care will become extremely difficult (Walsh and Ham, 2011).

The importance of regulation and surveillance introduced under the term governance remains a central element of the new system. The newly formed NHS Commissioning Board has been formed to regulate the actions of clinical commissioning groups. Its role will entail providing the funds for commissioners and ensuring that they make decisions which reflect both local as well as national health outcomes. Monitor will continue in its role as financial regulator, with the additional roles of setting costs and managing competition. As before the care quality commission will inspect and regulate the quality of all health providers (including private providers). Finally NICE has been tasked with the development of the NHS outcomes framework and specific outcomes for different patient groups.

A central tenet of all clinical outcomes is an emphasis on safety. Trust in professionals and service providers was undermined in 2010 with the publication of the Francis report into the failings at the Mid Staffordshire NHS foundation Trust. Therefore, as well as placing emphasis on evidence based efficiency and effectiveness, health outcomes also emphasise patient safety. Pollock and Price (2011) have argued that regulation has been weakened as regulators are now required not to impose unnecessary burdens on providers. Although safety is a priority its enforcement appears weak, the responsibility and accountability has been moved onto professionals and organisations, with failures now being met with loss of income or criminal prosecution.

Summary:

The introduction of market principles into health care has radically changed the operating culture of the NHS (Bach, 2000). The balance of power between managers and healthcare professionals and between providers and purchasers has been shifted in light of the 'quest for choice and value for money' (Fournier, 2000, p. 67). Commissioners now have greater control over the delivery of services; providers need to be more aware of both the cost and quality of the services they deliver. With regards to health care professions generally, the introduction of the internal market into the NHS has been interpreted as both positive and negative. Hanlon (1996) has argued that the introduction of a market ethos into the NHS will ultimately erode the altruistic nature of professional practice. An alternative view is that through the marketisation of health services and the resulting management and bureaucratic infrastructure, professional practice and knowledge will become more diffuse and thus available to consumers and employers, however the same such bureaucratic structures will be utilised by professions in order to retain a sense of ownership and control over their work (Ackroyd, 1996). What both of these arguments acknowledge is that professionalism is not divorced from the context in which professionals practise. A change in the organisational ideologies and hierarchies of the NHS clearly affects professionals. Focusing specifically on allied health professions, although limited, there is literature suggesting that although initially poorly prepared the allied health professions have adapted their professional discourses to reflect central elements of policy reform. The second section of this chapter will focus on the empirical evidence concerning the work of healthcare professionals as a result of the policy trajectory outlined, and further establish the relationship between macro organisational and policy changes and micro professional practice.

Market orientation and professionalism

The need for cost effectiveness has long been recognised within health service delivery (Bach et al., 2008; Page and Willey, 2007). The introduction of the internal market into the NHS and its subsequent continuation has led organisations responsible for the delivery of health services to adopt a 'market orientation' this being reflected in their values or processes, the principal aim of which is the creation

of high value and desirable services (Hampton and Hampton, 2004, p. 1042). Key elements of a market orientation such as patient centred practice, a flexible workforce and cost effectiveness are reflected throughout the reforms outlined above. The adoption of a market orientation in health care has been shown to improve performance (Raju et al., 1995). There is an assumption that staff working in market orientated organisations reflect to some degree the ethos and values of their employers, and there is evidence to suggest that this is the case in private sector organisations (Whitchurch, 2008; Ruekert, 1992). Professionals working in the public sector are seen however, to be a different kind of worker, in that their values and beliefs are more fragmented reflecting a particular professional orientation as opposed to the central values of marketisation (Southon and Braithwaite 1998). The ethos of professionalism is seen by some as being fundamentally at odds with that of marketisation (Doyle and Cameron, 2000; Hanlon, 1998; Hafferty and Light, 1995; Wallace, 1995). This has led Baxter (2011, p. 9) to suggest that marketisation of the public sector is having an effect on individuals' 'professional values, sense of salience and professional identities'.

There is evidence to suggest that the introduction of market incentives into health care affects professionalism. Focusing on nurse midwives working in the USA, Hampton and Hampton (2004) attempted to measure the relationship between professionalism and market orientation. Adopting a quantitative methodology Hampton and Hampton utilised a variety of measurement scales to assess professionalism, perceived rewards, market orientation and job satisfaction. Acknowledging that the sample is representative of only one profession, Hampton and Hampton concluded that there is a strong relationship between professionalism and market orientation, suggesting that the two concepts are closely related in that they are both concerned with the standard of service provided to clients. The relationship between professionalism and marketisation has been questioned, by Poses (2003) who, again commenting on the US healthcare system, accused the introduction of market incentives as distracting professionals (doctors in this case) from their core professional values i.e. altruism and a core body of knowledge. The latter point is supported by Rastegar (2004), who argues that the introduction of evidence-based practice along with the industrialisation of health care is moving knowledge away from professionals, placing it under the remit of managers and

wider bureaucracies, a point echoed by Bach (2000). Both Poses and Rastegar offer critical commentary from the US and are concerned with the plight, in the most part, of the medical profession.

Empirical research investigating the argument that the introduction of the market dilutes or alters professionalism has been provided by a number of authors.

McDonald et al., (2007) conducted an ethnographic study looking at the effect on General Practitioners' motivation of recently introduced financial incentives for the quality of care provided. McDonald et al.'s findings demonstrated a change in practice for doctors and nurses with the former adopting a more managerial role, choosing to delegate the more technical aspects of their work to nursing staff.

Interestingly, McDonald et al., (2007) noted that the delegation of tasks previously undertaken by doctors to their nursing colleagues caused a degree of unease, with nurses feeling that their work was being scrutinised in more detail than before.

Although changes in practice were noted, McDonald et al., concluded that internal motivation or what could be regarded as professionalism was not affected. Cohen and Musson, (2000) used a qualitative case based approach to examine the

discourse of general practitioners at a time when the new GP contracts were introduced. Cohen and Musson's findings indicate that the concepts of

managerialism and marketisation were strongly represented by doctors in their accounts of their work, however, such discourses did not precede or replace what they felt was their central identity, that of a GP. Elston and Holloway (2001) adopted a grounded theory approach to investigate the perspectives of doctors, nurses and managers regarding changes in the organisation of primary care in the UK. Their findings suggest that on the whole, while the general practitioners were willing to take on and/or retain their role as leaders, they were hesitant in relinquishing power to either the nurses or managers. The nurses interviewed in this study were keen to be recognised and valued, and were eager to take on the extra responsibilities and roles relinquished by the doctors. Elston and Holloway (2001) concluded that differences in interpretations of professionalism led to some conflict between professions in light of the introduction of service reforms. This final point was observed by Grant et al., (2009) who, based on data from an ethnographic study focusing on the work of four GP practices at the time of the introduction of the quality and outcomes framework (DoH 2003), found that the extent of change in roles and

identities was highly individual with 'both winners and losers being located within rather than between professions' (Grant et al., 2009, p. 242). Based on the evidence reviewed it is clear that the relationship between marketisation and professionalism is complex and is not restricted to either profession specific or individual factors but should be seen to be a combination of the two.

Although limited in number, the empirical evidence seems to suggest that the introduction of market values into the delivery of health services has influenced the identity of health care professionals; this being primarily reflected in their discourse and day to day actions. It is important to note that the literature considered so far has almost exclusively addressed the identities of the medical profession and more specifically doctors working in primary care. Doctors working in this environment have traditionally been independent and entrepreneurial and it is not surprising to see that they have adopted managerial traits in light of the marketisation of health care. Taking into consideration the recent changes in policy discussed it will be of interest to assess the extent of these on GPs' professional roles and identities.

Although not researched, a number of commentators have suggested that GPs will, on the whole, reject the additional managerialism now incorporated into their roles and simply hire ex primary care commissioners to fulfil this role (Pollock and Price, 2011; Asthana, 2011). The empirical data, however, seems to suggest a more of mixed picture (Checkland et al., 2012). Research focusing on members of the medical profession working in secondary care indicates more unease with, and often resistance to, marketisation. Doolin (2002), again adopting a qualitative case based methodology, incorporating interviews, observations and documentation analysis, aimed to analyse the extent to which enterprise discourse was evident in hospital based doctors in New Zealand. He found that since the introduction of market values into health care delivery many doctors had changed their identity (as reflected through their discourse) to reflect market values. A point observed by Doolin, was that doctors changed their discourse depending on the context in which they were working. Doolin stresses, however, that although adapting to the introduction of the market into hospitals, doctors remained uncomfortable. This notion of dual identities has been demonstrated by Kitchener (2000), who again focusing on doctors working in hospitals, used a qualitative case based approach to investigate the impact of marketisation and professional identity. As in the previous studies cited, Kitchener

noted the adoption of managerial and market orientated discourses by doctors, and suggested that through this change in discourse, doctors were diluting their professional identity subsuming it within that of management. He goes on to suggest that they were in effect being “de-professionalised”. This concern echoes that of Hafferty and Light (1995), and may contribute to the rationale for the current focus on professional identity within medical education (Monrouxe, 2010; Thistlethwaite and Spencer, 2008).

The importance of context is apparent and may be explained when one considers the organisational complexities and hierarchies within hospitals (Reed and Anthony, 1993). In addition to this, those studies which have investigated other professions alongside medicine appear to suggest that changes in how doctors work, and subsequently their identities, has an impact on the professional identities of those around them.

Nurses and Allied health professionals

Nurses and allied health professionals have been the focus of recent NHS policies aimed at driving patient centred practice within health care services (Skills for Health 2006). Of note are the continued calls for team work in the delivery of health care by these professions and the demand for greater flexibility from these professions in the type of services they provide (DoH 2010a). When we consider the impact of marketisation on nurses and the allied health professionals the picture appears more complex when compared to the medical profession. Larkin (1988) has suggested that greater management and supervision of professional work may affect the semi-professions more than medicine. The empirical data, although limited in volume, appears to suggest that nurses and allied health professionals are struggling to incorporate aspects of marketisation into their identities, the result being a degree of self-reflection by these professions regarding their professionalism. In addition to this a number of the changes in how and where these professions work appears to be reinforcing as opposed to reducing their individual professional identities and cultures (Mackey, 2007; Mazhindu, 2003; Herdman, 2001; Brown and Greenwood, 1999). In light of the most recent reforms, researchers are beginning to focus on the effect social enterprise schemes are having on this section of the healthcare

workforce (Miller et al., 2013). A growing interest has emerged directed toward, if and how entrepreneurial skills should be developed in this section of the workforce (Sankelo and Akerbald, 2008; Drennan, et al., 2007; Cook, 2006). The introduction of social enterprise schemes across the NHS is a recent development, however, other elements of marketisation have been in position for some time, for example patient centred practice, skill mix and competency frameworks.

Professionalism and team work:

The need for more patient centred services has reinforced the call for inter-professional team work (Lowe and O'Hara, 2000). The concept of team work as a means of providing more joined up services was introduced as long ago as the 1920s (Consultative Council on Medical and Allied Services, 1920). Although primarily seen as a way of structuring the work force in primary care, team work is now regarded as a core attribute of patient centred care in the delivery of almost all health services (DoH 2008).

There is some evidence to suggest that team work improves patient outcome (McCallin, 2001), however the empirical evidence supporting what makes a good team remains limited (Neumann, et al., 2010). From a theoretical perspective there appears to be some agreement on what elements are required for teams to be effective. Clear goals and operational policies need to be in place, in addition to this, members of a team need to adopt a culture of mutual trust and respect with a willingness to share knowledge (Neumann et al., 2010; D'Amour et al., 2005). The primary purpose of team work in the delivery of health services is the provision of a range of knowledge and skills from a number of highly skilled clinicians all focusing on one client. For teams to be effective they need therefore, to be multi-disciplinary. A number of authors (Finlay 2000; Ovretveit, 1997; Laidler 1994) have defined multi-disciplinary teams as different professions working with the same client towards the same goal. This joint working could primarily take two forms; the first is when professionals work together with little or no exchange of information or changes to their working practices. The second is characterised by the overlapping of roles however, this often occurs in an unplanned way 'which may lead to duplication and possible fragmentation of roles and interprofessional conflict' (Pethybridge, 2004, p.

30). Taking into consideration the potential limitations of multi- disciplinary team working, Laidler (1994) and Ovretveit (1997) have suggested the concept of inter-disciplinary working as being more appropriate for patient centred care. Inter-disciplinary team working can be described as when professionals from different professions work in an 'interwoven' and overlapping way, where knowledge and skills are openly shared and roles are actively blurred (Pethybridge, 2004, p.30). Looking critically at the reforms in policy introduced over the past 25 years it seems apparent that it is this latter form of inter-disciplinary working which is being promoted.

With regards to professional identity there is a growing body of research indicating that the traditional demarcations between professional groups impairs the development of effective team working (Axelsson and Axelsson, 2009; Lingard et al., 2002; Freeman and Ross, 2000; McCallin, 2001; Easen, et al., 2000; Miller and Ahmad, 2000). Salhani and Coulter (2009), focusing on the micro-political struggles within inter-professional health care teams, conducted an ethnographic study in a psychiatric hospital in the UK. Using Abbott's (1988) concepts of jurisdiction and inter-professional competition, Salhani and Coulter argued that the traditional hierarchies (the dominance of the medical profession) within the hospital setting prevented some professions (nurses) from fully developing their professionalism. Cohen (2003) writing from an occupational therapy perspective, has suggested that the traditional elements of professionalism as conceptualised in the work of Abbott (1988) and Larson (1977) block the introduction of inter-disciplinary team work as the changes in attitudes required by individual health professionals are at odds with the concepts of jurisdiction and market closure. Reflecting the work of Salhani and Coulter (2009), the importance of context and its interaction with team work has been highlighted by Baxter and Brumfitt (2008). They conducted a qualitative case based study focusing on inter-disciplinary teams working with stroke patients. Three teams were investigated, one based on an in-patient ward, one in a specialised stroke unit and one based in the community. Their findings suggest that in the case of the stroke unit and the community based teams the traditional hierarchies between the professions were being eroded in favour of the more inter-disciplinary model described above. However this was not the case with regards to the ward based team where the traditional demarcations between the various professions

involved were still evident. Xyrichis and Lowton (2008) have conducted a literature review focusing on what factors facilitate or prevent interprofessional team work. Taking into consideration the review was descriptive as opposed to critical; their findings indicated the importance of clarity in both purpose and roles for effective team working. From the work outlined above it would appear that the “rhetoric” of inter-professional team working fails to take into consideration the sociological theories of the professions. Although not necessarily providing an answer as to how inter-professional teams could work, the sociological perspectives of professional practice do provide some indication as to why inter-professional teams do not always work. What is interesting from Baxter and Brumfitt’s (2008) research is that context seems to play a role in how teams of professionals work together.

The redistribution of roles across professions:

A key element of inter-disciplinary working is the need for role overlap, an aspect it has been argued, that is at odds with the very definition of a profession (Baxter, 2011). In addition to inter-disciplinary working the marketisation of health care has led policy makers to review the current roles and activities individual health professions play in the delivery of health care services in the UK. The redistribution of roles across professions has in part been the result of changes in how doctors work. However, this redistribution of skills across the health care workforce is being facilitated by changes in policy which are directly impacting on the way allied health professionals and nurses practice (Hoskins, 2012; Nancarrow and Borthwick, 2005). The NHS has been accused of not being designed around the needs of patients, having outdated working practices, with the current demarcations among staff being unrepresentative of clients’ needs. (DoH, 1998; 2000; 2010). One of the main ways the NHS can address these apparent shortcomings is by looking at how the current workforce is employed. Based on the theory of business process re-engineering (Hyde et al., 2005), workforce redesign, i.e. a redistribution of skills across a range of staff within health care organisations, may create a more flexible and responsive workforce. The overall aim of this being an improvement in the quality of care and a more patient centred approach, in that services are designed around the needs of the consumer (Adams, et al., 2000; Bach, 1998). Addressing the aims of value for money and productivity, there is some research to suggest that a focus on skills, for

example, through staff development and training, has a positive impact on productivity and profit (Hyde et al., 2005; Nolan, 2004; West et al., 2002). Research carried out in the UK by Bach (1998) in the mid-1990s, demonstrated that by altering the skill mix of the health workforce, employers are able to save considerable amounts in terms of pay expenditure. Although blocked initially by trade unions and professional bodies, the move towards role re-profiling, skill mix and a more transparent pay structure for all health workers (with the exception of doctors and dentists) has now been introduced (DoH, 2004). The work of Goode and Greatbatch (2005) illuminates to some degree the relationship between professionalism and the re-distribution of roles between professions. In a qualitative study involving interviews and participant observations, Goode and Greatbatch (2005), investigated the boundary work between nurses and call handlers working for NHS Direct. Their findings suggest that nurses reinforced their professionalism as a means of constructing a boundary between themselves and the call handlers. Hoskins (2012) provides a discursive as opposed to an evaluative summary of the literature concerning the effects of marketisation and professional identities. Focusing specifically on the emergence of non-medical roles in emergency care, she argues that as a result of changes in policy there has emerged a spectrum of overlap between professions. At one end of the spectrum professionals are simply duplicating tasks whereas at the other professionals are substituting for each other's roles. Although concerned with just one aspect of medical care, Hoskins develops an academic argument to suggest that the effects of policy change are not uniform within or across professions.

The introduction of Agenda for Change (AfC), in 2004, created a single pay system for all NHS employees. AfC replaced the previous Whitley Council pay structure through which different professions had varying pay and employment conditions. All NHS staff, with the exception of doctors, dentists and some senior managers, are now banded on a pay scale ranging from 1-9. The 9 pay bands are demarcated by the level of knowledge, skills and responsibilities required for a particular role. Staff progression with regards to pay is now linked to the individual's ability to demonstrate that they have the required knowledge and skills for the next pay banding. At the time AfC was introduced individuals' roles were mapped onto the knowledge and skills framework (KsF). The KsF defines and outlines the knowledge

and skills staff needed in order to do a particular job. As with many of the recent policies introduced into the NHS, empirical research looking at the effect of these changes is only just beginning to emerge. One of the first academic reviews of AfC was conducted by Hyde et al., (2005). Based on a case study drawn from 5 sites they concluded that for role and pay redesign to be effective it needs to be driven locally and take account of the needs of all stakeholders. Hyde et al.'s findings could be viewed as supporting the new freedoms foundation Trusts now have with regards to how they manage their work force.

There are now clear mechanisms in place within the NHS for skills appraisal and development. The introduction of Agenda for Change (DoH, 2004) and the Knowledge and Skills Framework (DoH, 2004a) enables managers (and staff) to assess the skill requirements for individual roles and services. Giving employers a central role in this process is a key element of the skills agenda. This is not to say that such mechanisms are not without their critics (Gould et al., 2007); the development of a skills based workforce could lead to a system in which technical competencies are favoured over more aesthetic ones, as the former are more amenable to rationalisation (Mazhindu, 2003; Miles et al., 2001; Southon & Braithwaite, 1998). In order to address the claim that the introduction of the new pay scales facilitates role blurring and skill mix, McClimens et al., (2010) used focus groups to look at how staff working in an intermediate care team felt about the introduction of AfC. Their findings suggest that instead of promoting transferability of skills and the blurring of roles, the introduction of a more structured, reward orientated model of human resource management reinforced the demarcations between practitioners and the need for individuals to be more specialised in order for them to progress. The re-distribution of skills across the health workforce, although supported from a managerial perspective, has had mixed feedback from staff. Adams et al., (2000), pre-empting the findings of McDonald et al., (2007), have suggested that changes in who does what with regards to health care delivery has placed greater pressures on nursing staff, as they are required to take on more challenging roles often at the expense of other tasks traditionally associated with nursing. In a recent qualitative case based study, Bach et al., (2008) reported that the implementation of work force re-design and skill mix has failed to acknowledge

the anxieties felt by staff (nurses). Of particular interest was the notion that qualified staff felt threatened in their roles by nonqualified or support workers.

In addition to the changes outlined above, recent developments with regards to the types of skills the NHS workforce possesses have been introduced. In 2008 the Health Sector Skills Council, Skills for Health, published its strategy for the modernisation of career pathways for allied health professionals (AHPs). The 31 page document provides information for managers, practitioners, commissioners and providers of education regarding the competencies AHPs should possess or could develop in order to address the changing health care needs of the nation. The strategy joins a number of initiatives which aim to modernise NHS careers. These include documents outlining radical changes to how doctors (DoH 2003a), nurses (DoH 2006a) and more recently health scientists (DoH 2008b) are educated and progress in the NHS. Developed in consultation with professional bodies, the competency based career framework for AHPs details 'what individuals need to do and know in order to carry out specific work activities' (DoH, 2008a, p. 20). The hope is that the development of these competencies will ensure consistency of practice, provide clear options for career development and facilitate the development of a flexible and responsive health care workforce (DoH, 2008a). Building on these changes the most recent reform of health care education (DoH 2010a), underlines the need to move away from professional silos for the delivery of services. Emphasis again is placed on patient centred practice and the need for employers to have more say in the types of skills and competencies the future workforce will have.

The types of skills health professionals have should represent the needs of the clients they serve, and so a demand based system of professional education has been introduced (Page and Willey, 2007; Payne and Keep, 2003). The introduction of a competency based skills framework for health care practitioners is a fundamental shift in how the skills health professionals have are developed. In the past, skills had been determined by diverse groups - higher education institutes, professional bodies and overly complex centralised organisations - all attempting to predict the needs of industry. The introduction of a demand-led system places the power to determine what skills should be taught in further and higher education institutions firmly in the hands of employers and the various external agencies determining health care services.

There are, however, concerns that the introduction of a skills based work force could have a significant influence on both professional practice and the overall existence of professions as they are currently recognised (Duckett, 2005). Doyle and Cameron (2000, p.1023) have suggested that ‘as the “core” skills and responsibilities of the different groups change, the organisation of the NHS labour force will be increasingly out of line with the traditional map of the healthcare professions’. The characteristics of any profession are thought to be developed through a process of socialisation, this occurring during pre-registration education (Sparkes, 2002) and through shared experiences in the workplace (Hyde et al., 2005; Lingard et al., 2002). A system which potentially dilutes this socialisation process may inevitably fragment both the knowledge and practice of currently distinct occupational groups. Such an outcome may enhance professional practice and deepen professional integration; on the other hand, it may lead to professional protectionism (Cohen, 2003) and greater demarcations between groups, as individual professions attempt to claim legitimacy over distinct areas of practice and reinforce their professional identities (Hall, 2005; Brown & Greenwood, 1999). In light of the empirical work concerned with interdisciplinary team working there appears to be support for this latter argument. Using the professional project (Larson, 1977) as a means of conceptualising contemporary professional practice, gives support for the notion put forward by Southon and Braithwaite (1998, p. 23) that the current restructuring of health care services are ‘fundamentally affect(ing) the nature of professionalism’. As with the introduction of market forces into the types of services available, it may be that by focusing on who delivers services, recent NHS policies increase the already embedded competition between professional groups. A third outcome may be that the traditional characteristics supposedly associated with public sector professionals are lost altogether, being replaced by characteristics more akin to the private sector, namely individualism, organisational allegiance and a consumer orientation, that privileges value for money over quality of care (McDonald et al., 2007; Stubbings and Scott, 2004; Hanlon, 2000).

Consistency of practice is a key area with which the modernising health careers initiatives are concerned. There have been, and continue to be, highly publicised failures and inconsistencies in the services health professionals provide (Walshe and Benson, 2005). A consequence of this has not only been a focus on the knowledge

and skills professionals have but also on how professions are regulated (Wills report 2012). Changes introduced in policy (DoH, 1997, 2000a) and legislation (1999 Health Act) have radically altered how health professions are regulated (DoH, 2000). With regards to allied health professions, the Council for Professions Supplementary to Medicine has been replaced by the Health Professions Council (HPC) (DoH 2000). This new regulatory body has been given tougher powers to tackle poor conduct and performance, has a role in the quality assurance of professional education, and for the first time introduced mandatory continued professional development linked to re-registration and the right to practise. The primary role of the HPC is to protect the public. This is accomplished by keeping a register and a record of all allied health professionals' education, performance, behaviour and health. At the time of the HPC's introduction the professional body for Physiotherapists, the Chartered Society for Physiotherapists (CSP), reacted angrily to the proposed changes in regulation. Its concerns and recommendations, however, were not reflected in the final proposals for allied health professionals (Frontline, p6. June 2000). Of significance is the development and implementation of common standards of practice for all professions which come under the regulative powers of the HPC. The HPC regulates 14 individual professions which now share common standards of performance and ethics. This commonality of standards of practice could be seen as another means of blurring the boundaries between professions. In addition to the change in how allied health professionals are regulated, there have been a number of initiatives concerned with the modernisation of health care in the UK which could potentially impact on professionalisation. The introduction of external agencies tasked with monitoring and informing health care delivery for example NICE and the Care Quality Commission, in addition to the re-invigorated culture of audit at the local level could be seen as removing clinical decisions away from the individual professional (Miles et al., 2001). The plurality of relationships between individual professionals, professional groups and external institutions has created a system of governance which is more open and complex and it could be suggested disadvantageous to the once powerful professional bodies whose primary role was to regulate their members (Newman, 2006). The introduction of external agencies with a responsibility for the content of professionals' education and practice could be seen as diluting the professionalisation processes and professionalism of those professions involved.

Summary:

Although pressing for different goals at different times it is clear from reviewing the trajectory of policy reforms affecting the NHS over the past 25 years that there has been and continues to be a clear path toward marketisation of health care services in England. Concepts embedded within the fostering of a market orientation include patient choice, a flexible workforce and greater employer authority over where and how services are delivered. Reflected by an emphasis on team work and skill mix and complemented by changes to pay and regulation there is strong empirical evidence to indicate that the pursuit of marketisation has affected the roles and boundaries of healthcare professionals. Although relatively underrepresented in the empirical literature, there is a strong argument to suggest that the changes introduced to health care provision have had an impact on the roles and boundaries of allied health professionals. Although recognised as a significant element of the healthcare workforce, there has been a clear lack of focus on the effect of policy changes on the allied health professionals

Based on the literature reviewed in this chapter and the preceding chapter, there is also evidence to support the relationship between roles and boundaries, and professional identities and the effect context has in shaping political, organisational and institutional contexts are key elements in the construction of professional roles, boundaries and identities. These do not operate in isolation but appear to be mediated by individuals and groups. Emerging from a critical engagement with the literature are the following propositions which shaped and informed the decisions made concerning methodological approaches, these are:

- Current changes in both the context and definitions of health care activities have led to a negotiation of occupational roles and what constitutes a professional activity.
- Role negotiation and professional activities will vary depending on the context of service delivery.

- Developments in the NHS have led or are leading to the development of a new kind of health professional.

Chapter 4

Methodology:

One way of positioning my research, and myself as a researcher, in the wider academic and research community is through the exploration of methodology.

The purpose of this chapter is to provide a narrative account of my research outlining the development of my methodology and methods in relation to the research questions and underlying propositions. Focusing on epistemological and ontological questions allows for a cohesive description of the relationships between the generation of knowledge (epistemology) that is recognised as such (ontology), and is important in order to construct a logical and coherent approach to social science research (Delanty and Strydom, 2003).

I have chosen to write in the first person in this chapter as I feel that the processes of exploration and development involved in shaping one's methodology and the conduct of qualitative research are an inherently personal one (Jordan and Yeomans, 1995). It is also important to note that the construction of this chapter occurred retrospectively to elements of the empirical process and as a result my writing serves as a reflection upon, as well as a rationale for, my chosen methodology.

Initially this chapter will revisit the research question in order to detail the theoretical, epistemological and ontological assumptions embedded within it, and in the process provide a conceptual rationale for my chosen empirical approach. Following on from this the chapter will detail and provide justification for the chosen methodology, including key decisions concerning the study design, sampling, data collection, analysis, ethics and, finally, rigour. As already indicated although delineated in this fashion I feel it important to stress that these components do not exist in isolation but are tightly interwoven.

A key component in the entire research process has been the centrality of reflexivity or as Doyle (2013, p.248) has described, the 'capacity to think'. Crucially, this capacity has enabled me to become aware of and appreciate (to an extent) the convoluted relationships between myself as a researcher, the often abstract

presentations of theoretical interpretations of research and the lived world experiences of the respondents as encapsulated in the data (Mauthner and Doucet, 2003). Although presented in a somewhat linear fashion, this chapter presents a narrative which is ongoing, charting my engagement with, and interpretation of, ontological, epistemological and practical rationales. These interpretations are framed in light of the procedures and processes drawn upon in order to answer my research question. The overall aim of this chapter is to make transparent and justify the decisions made during the research process. It is hoped that by making my approach overt dialogue is permitted with regards to the relationship between methodological assumptions research design, data collection, analysis and ethical decisions.

I feel that it is important to make clear my chosen methodology and methods to help contextualise the following narrative. Consideration was given to a number of theoretical approaches including phenomenology and grounded theory, however as discussed in this chapter, a question led approach privileged the adoption of a broadly ethnographic approach. In order to address my research questions and the underlying propositions I decided to adopt an ethnographic extended case based design. Two cases were drawn from a secondary care context and two cases from a primary care context. Cases were identified on the basis of being able to question my underlying propositions. Data was generated primarily through semi-structured interviews and non-participant observations of both formal and informal interactions between allied health professionals. Analysis and interpretations were developed using a broadly thematic approach. These decisions evolved through careful consideration of methodological interpretations and their associated implications with regards to structuring empirical work.

Conceptual rationale:

The aim of my research is to provide a detailed, contextually bound account of individuals' perceptions of their roles and working practices.

The research questions are:

- How do allied health professionals perceive their current working practices and how do these fit within the larger organisation?
- How do individual professionals view their identities and roles within the multi-disciplinary team and the wider organisation?

The following propositions frame the research questions:

- Current changes in both the context and definitions of health care activities have led to a negotiation of occupational roles and what constitutes a professional activity.
- Role negotiation and professional activities will vary depending on the context of service delivery.
- Developments in the NHS have led or are leading to the development of a new kind of health professional.

The research question arose from my own experiences as a physiotherapist specialising in elderly and neurological rehabilitation and conversations with colleagues working in the NHS. From my own experiences I perceived that there was a difference in my role and its permeability when working in a hospital setting compared to the community setting. In the former I felt that what I did as a physiotherapist was a lot more defined and as a result restricted, whereas in the latter context there was more of a sense of ambiguity with regards to my role.

My personal interpretations of practice were furnished through engagement with the literature regarding professional roles and boundaries. This, in addition to translating practice in the context of changes in healthcare policy, provided a back drop against which my research questions and underlying propositions were framed.

I cannot divorce myself from my past professional experiences; rather I recognise the need to bring them to the fore in order to make overt how they have influenced

the research process. Adopting a reflexive approach⁸ to the research process, and outlining the importance of stance, are important elements for consideration within this work. In saying this, I make no claim as to the utility of my professional experience as a means of validating my interpretations. I feel it important to distinguish my use of the term stance by which I mean the ontological and epistemological assumptions embedded within, and framing, the research questions, as opposed to a standpoint epistemology which in some way may privilege my interpretations (Crasnow, 2008; Mason, 1996; Stanley and Wise, 1990).

Engagement with the literature regarding the sociology of professions, identity, and social roles, has led me to interpret the term professional as contextually bound, fluid and negotiated. I acknowledge that these processes are bound within the wider social, organisational and political spheres of individuals and groups. There is also the assertion that professional identities are open and fluid, and crucially can be represented in part by what people do and say. My focus is on the perceptions of individuals regarding their work; and the association of context to these perceptions. The construction of the questions centres on individuals, specifically what they think about their work as professionals. In addition to this there is an acknowledgement that their work is contextualised somehow by the organisation in which they work and through the relationships they form with other members of the multi-disciplinary team.

Inherent within my interpretation of the concepts of profession, professional and professionalism are a number of epistemological assumptions reflective of contemporary social research. To begin, there is a fundamental acknowledgement of relativism. The focus on individual perceptions and their contextual and temporal nature reflects a view of social reality as simply a point of view. Of importance however, is the argument that such a stance rules out any possibility of common understanding. Although not accepting universalism as interpreted from a positivistic perspective I favour the interpretation put forward by Habermas (2002), and indicative within Giddens (1984) that describes sociological analysis through the creation of second order concepts, that of constructive universalism. Universalism is formed through interpretative agreement. Of importance is the recognition of the

⁸ By this I mean a critical self questioning of my involvement in the research process

hermeneutic foundation of social interactions and the resultant constitution of social reality. Acknowledging this anti-essentialism view privileges social reality as being open to negotiation and hence fluid. In essence my epistemological stance is reflective of ethnography as opposed to phenomenology, the implications of this are reflected in both my data generation methods and analysis (Hammersley, 2006; Jeffrey and Troman, 2004; Patton, 2002).

There are both ontological and epistemological implications inherent in adopting this stance the influence of which has extended into both my research design and analysis. With reference to the former is the concept of reflexive pragmatism⁹ underpinning my decision making (Alvesson, 2002). Of importance with regards to the latter is the emphasis placed on interpretation on behalf of the researcher and the inferred shared understanding and acceptance by the research participants. Extending from this is the ability of research participants to validate findings (Lather, 1986). Although criticised by Hammersley (1992), I accept the view that research can be made more robust through the reciprocal exchange of interpretations and as a result chose to take my interpretations back to available participants as a means of validation.

The second significant feature of my conceptual interpretation of my research questions is the importance of context. I am aware that by recognising context as a significant element within my research questions I am placing emphasis not only on individuals and their perceptions but also the social conditions in which they operate. Moving beyond the divisions between structuralist and interpretivist paradigms, my overall interpretations of the social world reflect the work of contemporary writers such as Giddens (1984) and Bourdieu (Bourdieu and Wacquant, 1992). Of importance is that the interpretations offered by Giddens concerning the constitution of social reality (1984) and sociological enquiry (1993) have contributed heavily to the development of my epistemological and methodological stance. My preference for Giddens over Bourdieu I feel is an inherently personal one. My overall interpretation of Bourdieu is similar to my impression of Foucault in that both appear

⁹ Although attempting to provide the “best data” I can I am aware of the ambiguity inherent in my chosen approach

overwhelmingly negative regarding our social condition, and in the context of my research I feel lessen the scope for agentic action.

It is worth commenting that although interpreted and justified in light of the work of Giddens, the research questions and propositions developed in part, out of my personal experiences as a practitioner, and my engagement with empirical and theoretical literature concerning professions and professionalism. The grand narratives proposed by Giddens did not appear within my thinking and decision making until I began to interpret my data. I acknowledge that as the research progressed in particular with regards to the theoretical interpretation and positioning of the data, the constitutive role of theory becomes increasingly transparent (Delanty and Strydom, 2003; Burawoy, 1998). This is important in so far as the relationships between grand social theory and my interpretations were formed through the analytical process, as opposed to being pre-determined.

In summary, the primary ontological stance taken is that social roles are actively constructed through interaction with others and the social environment, this being in the form of language (written and verbal) and action (Baszanger and Dodier, 2004). In addition however is the assertion that the social environment (or social structures) facilitate or constrain these interactions. The inter-relationship between social actors and social structures has been outlined extensively in Giddens' (1984; 1993) theory of structuration, and is increasingly being adopted by researchers investigating the social positions of health professions and professionals (Hotho, 2008; Hardcastle et al., 2005). Chiefly my research questions are inherently qualitative and more specifically ethnographic (privileging the cultural and situated nature of professional roles) and as a result necessitate a methodological approach which is reflective and responsive to the cultural and contextual nature of the phenomena under study. The primary purpose of making my position overt, as a researcher within the research process overall, is to provide a structural coherence to my work and thus strengthen its overall credibility (Krefting 1991).

Methodology:

In detailing my methodology I intend to present a logical argument for my chosen methods of enquiry and introduce the framework which has guided my decision making through the research process. By making my thinking and decision making transparent I have intended to provide assurances as to the overall dependability of the research process.

Delanty and Strydom (2003, p. 4) have defined methodology as 'the systematic investigation of the various rationale and procedural principles and processes which guide scientific enquiry'. By positioning myself within the very broad camp of qualitative research, I am announcing a number of assumptions held about the research question and the underlying propositions. With regards to methodology such a classification requires much further refinement. I also acknowledge that classifications alone do not determine a course of action, and as such issues of method and action need to be explored and explained.

Contemporary debate regarding methodological explanations within sociology specifically and the social sciences generally has moved from the simple justification of qualitative enquiry based on and within the various naturalistic schools of thought (Sim and Wright, 2000; Depoy and Gitlin, 1998; Patton, 2002), to the broader debate which recognises the need for the flexibility of methodological approaches. This transition has been described by Patton (2002, p. 38) as the move away from 'routine ways of thinking and paradigmatic blinders (which) constrain methodological flexibility and creativity by locking researchers into unconscious patterns of perception and behaviour', toward methodologies driven by enquiry, as opposed to predetermined 'simple and predicted sets of principles' (Mason, 1996, p. 4).

The need for a coherent rationale which addresses the relationships between the researcher, the researched, knowledge and known remain, and as such need to be recognised and made explicit within the structure and process of empirical work (Atkinson, 2002; Button, 2000). This is not to say that sociological disciplines should be simply replaced with philosophical assumptions (as this would be to replace like with like). But such assumptions should be seen as the 'underlabourer' of the practical action which is empirical research (Hammersley, 1995, p. 19).

Acknowledging the pluralistic nature of qualitative research and the move toward a question led, as opposed to a principle led, approach to empirical work, provides the

researcher with a high degree of freedom, however, it does not come without its challenges (Gonzalez, 2000). The framing and synthesis of personal beliefs and assumptions within epistemological and ontological referents often leads the qualitative researcher to feeling 'bent out of shape' (Lieberman, 1999, p. 47), a sensation I have been all too familiar with. Questions regarding paradigms and "schools of thought" can be confusing. It is of some relief to know that such tensions are not unusual (Byrne-Armstrong et al., 2001; Pallas, 2001) and are part and parcel of qualitative research (Denzin and Lincoln, 2005). I am aware that many researchers describe the research process as a journey. At the beginning of my research I considered such language to be too abstract and personal. It is only by engaging in the process of research that I now not only accept, but embrace the analogy.

Ethnographic case studies:

Reflecting a question led approach to methodological design, my research questions and the underpinning propositions assert that individuals have a valid interpretation of their social world, but in addition to this, the social world somehow influences this interpretation. Decisions regarding choice of methodology therefore needed to reflect these interpretations.

In order to structure an approach which would allow me to answer my research questions and address the underlying propositions I chose to adopt a critical ethnographic approach. Although the term ethnography is open to debate amongst social scientists (Hammersley and Atkinson, 1995) the definition provided by Hammersley (2006, p.4) where emphasis is placed on 'the importance of studying at first-hand what people do and say in particular contexts' created a sense of balance between question and stance.

Although acknowledged and established the term ethnography encompasses a very broad church with regards to sociological research (Gonzalez, 2000). In light of post-modernism, ethnographic principles have been interpreted and refined to reflect a number of contemporary epistemological stances (Anderson, 2006; Atkinson, 2002;

Hammersley and Atkinson, 1995). With regards to my research, the principles embedded within critical ethnography, namely the acknowledgement of the role of theory as both constitutive and emergent from data (Haralambos et al., 2008), in addition to the work of Dorothy Smith¹⁰ (2002; 1987), which emphasises context and a focus on social relations within organisations, acted as key referents. I am aware of the potential negatives of such an approach, in particular the inherent possibility of theory dominating and silencing interpretations directly from the data. The positioning of emergent theoretical interpretations within the analytical process is an important consideration.

I have proposed that context in some way shapes the roles and boundaries of allied health professionals. Designing research which could address the significance of context led me to frame the ethnographic enquiry within defined cases. Within qualitative research a case can refer to an individual, a group or an organisation (Gomm et al., 2000). Reflecting the research questions, cases were defined as a team of allied health professionals working in the same context with the same client group. The decision to select a case based approach was in the main pragmatic as I felt that in order to make the research manageable I needed to set the parameters within which data would be generated. Defining cases as inter-professional teams it was hoped would provide contexts where roles and boundaries between professions would be apparent (or not) and thus provide data which could address my specific questions. I am aware, however, that restricting the focus of the cases as I have/did, limits to a degree the transferability of my findings. As will be explained however, this limitation was addressed in part through the adoption of an extended case methodology.

The use of qualitative case studies has been advocated by Yin (2009, p. 13), who suggests that case studies are useful when the researcher wants to take account of 'contextual conditions, believing that they might be highly pertinent to [the] phenomena of study'. Yin (2009) has operationalised such an approach and describes a method where multiple cases are studied in different contexts, each case being studied individually in depth and then compared with other cases. The

¹⁰ In addition the importance placed by Smith on the interaction between researcher interpretation and the use of theory in the construction of understandings concerning social phenomena

term used by Yin to describe such an approach is 'multiple embedded' (Yin, 2009, p. 40). Central to Yin's development of comparative case studies is the need to identify and define the unit of analysis. Having a central referent point common to all cases allows for comparisons to be made. Crucially in Yin's descriptions of multiple-case studies is the application of replication logic (ibid, 2009, p. 54). Applying this logic requires that cases are selected on the basis that they will either produce the same results (literal replication) or predicted contrasting results (theoretical replication). Yin stresses the distinction between replication logic and sampling logic with the latter not being applicable to comparative case based research on the grounds that cases are by definition unique.

Although Yin's work provided a useful structure through which to frame my work the underpinning logic of replication lacks congruency with the ethnographic tradition (Hammersley, 2006). Within ethnography emphasis is placed on the uniqueness of an individual's or groups' experiences of everyday life (Gomm et al., 2000). In order to accommodate the uniqueness of each case yet allow analysis across cases I drew on the work of Burawoy (1998), in particular his description of the extended case method. Burawoy describes the extended case method as a means of linking individual ethnographic cases through the use of emergent and established social theories. Central to this is the extension out from unique cases in order to connect each case to one another and the wider social world. In a similar fashion to Giddens' structuration theory, Burawoy views the extended case method as a means of linking the 'micro' to the 'macro' (ibid, p.5).

In contrast to Yin's emphasis on replication logic, Burawoy asserts that within ethnography replication is impossible as the ethnographic encounter is, in its very nature, unique. In addition to this the field in which encounters occur is in a constant state of flux. As an alternative Burawoy argues for a reflexive model of science, echoing Giddens' (1994) concept of the double hermeneutic, through acknowledging the reciprocal relationship between scientist and subject. The application of reflexive science privileges the role of theory, positioning it centrally in both case selection and data analysis. Individual cases are connected through analysis which is made coherent by embedding theory throughout the research process. Theory provides the focus of any cross case analysis. A key issue for the reflexive researcher is the acknowledgment of the reciprocal relationship between data collection and analysis,

and that the process of analysis moves from the data as representing the instance to interpretations grounded in and anchored by theory.

Identifying and selecting “appropriate” cases

The theoretical assertions as expressed in my research questions and propositions guided the selection of my case studies, the data collection, and analysis. Cases were defined by context and focus and were selected on the basis of being seen to provide opportunities to answer my questions. The case studies needed to provide opportunities where allied health professionals worked alongside one another with the same client group in the same setting. In addition they needed to be drawn from two distinct clinical areas, namely a hospital setting (secondary care) and a community setting (primary care). This second point reflecting the propositions developed from the review of the literature. In order to bound the cases further I also chose to focus on clinical areas in which allied health professionals worked with patients with long term conditions. The rationale for this decision again stemmed from my engagement with contemporary literature and healthcare policy regarding the trajectory of healthcare services in England.

Overall the sampling process adopted can be described as purposeful (theoretical), in that cases were identified through discussions with service managers and selected based on their potential to address my research questions (Stake, 1995). In order to facilitate the subsequent cross case analysis I decided to select two cases from one hospital and two from one community service. All four cases were based in the same geographical area (i.e. they provided either primary or secondary care services in the same borough). With regards to secondary care, one case focused on the inpatient elderly rehabilitation service, the other on elective orthopaedics. The two primary care cases were selected from a possible four community based multi-disciplinary rehabilitation teams located within the borough.

Respondents drawn from within each case were sampled via convenience sampling (Depoy and Gitlin, 1998). Once the cases had been identified letters were sent to the respective service managers explaining the nature and purpose of the research

(Appendix D). Once the managers had agreed, I approached the teams in person and gave a short, informal presentation as to the purpose of the research and outlining their possible involvement. Written information detailing the research was also provided to the potential participants. Details of each case including the respondents recruited are provided in chapters 5 and 6.

A central issue with regards to the case selection, and more generally with comparative case based research, is the ability to generate meaningful interpretations. As already introduced, Yin (2009) offers insight to the use of multiple case studies and the importance of case selection in order to provide robustness to the overall research design. A key advantage of multiple case studies is the ability to study phenomena in more than one setting, strengthening any claim regarding the transferability of the findings. I acknowledge that although occurring in the same trust the cases drawn from secondary care cannot be regarded as literal replications of each other and need to be seen as individual case studies in their own right.

Based upon my initial propositions, specifically the importance of context, the case studies drawn from primary care offer contrasting situations from those derived from secondary care. Again the same criticism and defence offered with case selection in secondary care apply also to primary care.

A further question to be addressed is the validity of any cross case analysis involving all four case studies. The choice of an extended case study design for all case studies provides a foundation for cross case analysis, and taking into consideration potential scepticism regarding the literal replication of cases, provides analytical consistence through the entire project.

Case study construction:

An often over looked element of any case based research is the format of case write up and presentation (Yin, 2009). Being exploratory in nature my case studies lend themselves to a number of formats of presentation (Runeson and Host, 2008; Menzies, 1960). The presentation of the case reports follow a linear-analytical model (Yin, 2009, p. 176). I am aware that the primary audience for my work is a PhD

examination panel and as a result this influenced to a point decisions regarding the overall presentation. Of importance is the utility of the interpretations and potential implications to wider audiences. An element of consideration in the overall composition of the thesis was the accessibility of the data and identified implications to study participants and healthcare professionals generally. As part of the overall rigour of the work, data and interpretations were fed back to and commented on by study participants and service managers from the study sites. Taking these points into consideration I have attempted to produce a case study report which is reflective of a critical ethnographic style in that the overall reading of the thesis provides what Dicks and Mason (1998) have described as a critical 'meta-commentary that interweaves the voices of ethnographic participants with the wider context of the study'. Cases drawn from the two study sites have been presented together (see chapters 5 and 6), and embedded within them is key information contextualising the respondents' accounts. The data presented within each case serves primarily to illustrate the emergent themes, however, I am aware that in the development of each theme data also furnished the constitution of the individual case study analysis and the cross case analysis overall (Mason, 1996, p.144).

Data generation: Interviews and observations and documentation

As already indicated, my research questions centre on the perceptions of individuals'. The underlying ontological stance is that individuals are knowledgeable agents and as such have an informed awareness of their social spheres. Potential primary data sources were individuals who had experiences of the phenomena I wished to explore. In addition to this is the assertion that perceptions and views can be communicated through action as well as spoken language. Interactions and actions serve to illustrate social roles; this stance being reflective of the notion of praxis as being central to the formation of an individual's understanding. Finally, as well as what people say and what they do, another potentially useful data source is the artefacts individuals, groups and organisations create in order to communicate meanings (LeCompte and Schensul, 1999).

I feel it is important to distinguish between data sources and data. Extending the rationalisation of my research questions it is clear that the primary data sources are people, more specifically health professionals, and what they say and do in relation to their professional roles and boundaries. Additionally a further data source is formal documentation detailing the duties and responsibilities of individuals within the contexts they are working.

I am aware that a crucial element of consideration with any research is the ability of the data generated to answer the research question, as Mason (1996, p. 89) suggests, 'a judgement about whether data analysis is valid is a judgement about whether or not it measures, explicates or illuminates whatever it claims to'. My work focuses on the perceived roles and boundaries of allied health professionals working in different settings and as such the choice of data sources and generation methods centred on their ability to illuminate the phenomena under study.

In order to answer my research questions and explore my propositions a number of methods of data generation were considered. Primarily these were qualitative interviews, observations and documentary analysis. My selection of data generation methods was also influenced by my critical ethnographic methodology where observation holds a central position. My intention at the start of the research was to include all three methods of data generation. Once in the field it was apparent that the types of observations I was able to perform and the existence of documents detailing the roles and responsibilities varied within and across cases. As well as detailing the actuality of my data generation I will briefly provide an overview of qualitative interviews, observations and documentary analysis as a means of justifying my chosen approaches.

Interviews:

The decision to select interviews as a method of data generation stemmed from and is reflective of the epistemological and methodological concerns already outlined. Although one of the most commonly recognised forms of qualitative data generation (Mason, 1996), the structure and formation of qualitative interviews varies with respect to research question and researcher (Patton, 2002). In designing my

research (and as part of the NHS and university ethics application processes) I developed an interview schedule based around my research questions and propositions.

Prior to conducting the first two case studies in secondary care, interviews were conducted with the service managers for planned and unplanned care, and the professional leads for physiotherapy, occupational therapy and speech and language therapy. In addition, one interview was conducted with the physiotherapy respiratory team leader. The primary aim of these pilot interviews were to provide background information regarding the types of services allied health professionals were involved in within the trust and identify cases which could answer the research questions. These pilot interviews also provided an opportunity to become familiar with the process of data generation and recording, as well as an introduction to possible processes of analysis.

It became apparent based on these initial interviews that the schedule I had designed and used as part of my ethics applications was limited in eliciting the type of information needed to fully address my research questions. The interviews served only to illuminate the ideal as opposed to the real (Bourdieu, 1977). Reflecting critically on these early interviews the decision was made to depart from the interview schedule and simply ask the respondents about their day-to-day work. The rationale was simple, how better to find out about an individual's day-to-day life than to ask them (Collins, 1998).

Often a distinction is drawn between semi-structured or unstructured qualitative interviews, the implication being that the latter permits greater opportunity for exploration by the researcher whereas the former is more restricted to predefined topic areas (Bowling, 2009). A number of authors have catalogued the advantages and disadvantages of both methods (Bowling, 2009; Patton, 2002; Depoy and Gitlin, 1998), however separating qualitative interviews into these two categories has also been brought into question (Collins, 1998). Denzin (1977, pp. 112-113) describes the interview process as an 'interactional situation', and as such necessitates some form, no matter how loose, of structure.

I agree that the distinction between structured and unstructured interviews can be misleading when put into practice. Reflecting on my experiences, the interview

process, although initiated by me, was equally determined by the respondents; they had read the preceding information regarding the research when consenting to take part and as a result came to the interview with their own agenda. My agenda, although not dictating the interaction (as in the early pilot interviews), served as a referent point to return to when the discussion appeared to wane. The interactional element of the interview created data which represented a dialogue as opposed to a monologue detailing the respondent's accounts of their day-to-day work (Taylor 1991).

Although sensitised to data through theory, sensitisation also occurred through the ethnographic encounter. Acknowledging the unique nature of each case and the reciprocal relationship between me as the researcher and the respondents permitted data generation to be responsive to emergent themes. Yet the theoretical assumption embedded within the propositions served as a link in order to draw the cases together, the analytical process allowing comparisons and aggregates to be made.

Data generated through interviews were captured by digital recording. All recordings were then transcribed verbatim. At this point the transcripts were sent to the respondents for correction or clarification. A key implication with regards to my assertion of the negotiated nature of qualitative interviews is the acknowledgment of self in the research process (Sword, 1999). An awareness of self as the researcher within the data generation process is a central component of the concept of reflexivity. Simply stating that as a researcher I adopted a reflexive stance diminishes the very nature of the concept. One possible means of reducing self from the research process would be to adopt an action research approach, however if the construction of the final research document lies solely with one individual then the question of whose voice is being privileged remains (Collins, 1998).

The process of data generation through the use of interviews served to contribute to the formation of a 'polyphonic narrative' (Jorden and Yeomans, 1995, p. 394) accounting for the descriptions of the respondents' day-to-day work. The construction of a 'polyphonic narrative' is made more possible by further involving respondents in the research process through the validation of the interpretations

drawn from the data. In addition the overall utility of the final product of the research legitimises the creation of, what are in essence, second order concepts (Daly, 1997).

Extending from the acknowledgment of self is the consideration of the latent and potential power differentials between interviewer and interviewee (Sword, 1999). Of significance in my work was that some of the respondents involved in the research from all four cases had been ex-students who I had taught during their undergraduate physiotherapy education. Collins (1998) has suggested that a fluctuating balance of power exists between interviewer and interviewee, a consequence of which is that as an interviewer we have 'a limited control not only over what is being said but also who we are during the interview'. Reflecting on my own practice I disagree with Collins's account. As a researcher, equally as a respondent, we are active in the construction of our selves, although I acknowledge that this is influenced by motives, emotions, context and others. Aligning closely with my epistemological stance as indicated, although aware of the potential power dynamics during the interview process, I feel strongly that as an active reflective researcher I was able to exercise principles such as fair exchange (Daly, 1992) in the pursuit of a dialogue with the respondents. This was evidenced through the interview transcripts which show a conversational as opposed to a confined approach to interviewing (see appendix A, section 2).

Two final considerations concerning the use of interviews as a means of data generation are firstly the assumption that what people say is a true representation of their perspectives. Second is the concern that through the process of analysis the voice of the individual is lost. The creation of a polyphonic narrative silences the individual (Hammersley, 2006).

Addressing the first point, I acknowledge that viewing the interview as a process of interactive dialogue locates the meanings constructed from that dialogue firmly within the context in which they are produced. This brings into question, however, the legitimacy of any inferences made beyond the context of that meaning construction. The outcome of this line of logic reduces the role of the researcher to simply reporting the data and denies them any sort of claim to knowledge or scope for interpretation (Button, 2000). I echo Mason's (1996) assertion that although questionable the validity of any inferences beyond the context in which the data was

generated lies in the utility of the final product. This is not to say that rigour in both method and analysis is unimportant, but serves to acknowledge the inherent contingency located in qualitative research.

On the second issue raised, I agree that through the creation of a polyphonic narrative the voices of individuals are lost to a degree; however, I would argue that one of the primary purposes of ethnographic research is to move the social to the sociological (Smith, 2002) and that by making the research process transparent the overall narrative is opened to judgement.

Field work:

In developing my methodology and subsequent decisions regarding data generation I initially intended to perform non-participant observations (Gold, 1997) of allied health professionals working together with patients. It was apparent, soon after entering the field, that this would not be possible. What emerged from the interviews with respondents across all four cases was that although joint working between professions with patients did occur, the frequency and structure of these sessions was sporadic and ad hoc.

In designing my research I anticipated that the format of my field work would be selective and intermittent (Jeffrey and Troman, 2004). The decision to only spend limited but targeted time in the field was based primarily on my availability. Undertaking my doctoral research as a part time student, and working full time as a university lecturer meant that finding space and time to spend in the field was difficult. I am aware that restricting my time in the field has had an implication on the data generated. Immersion within the study sites was never possible and as such possible temporal aspects of the respondents' encounters could not be considered, thus limiting the overall ethnography. The decision to limit my field work to only targeted time periods and events did cause a great deal of anxiety for me as a researcher new to ethnographic research as I felt that I was distancing myself from the ethnographic tradition (Hammersley, 2006). This, combined with the realisation that the intended focus of my observations had to be adjusted due to circumstances

encountered in the field, made me question the position and utility of this form of data generation within the research, and to an extent challenged my methodological approach overall.

The rationale for conducting observations coheres with my epistemological and methodological stance. The assertion that meanings are constructed through interaction, and are located within, but also form, the contexts of those interactions, is consistent with my relativist stance, and critical ethnography. My initial intention was to observe allied health professionals working together with patients, the focus of the observations being on the dialogue created centring on the negotiation of roles and boundaries (Jordan and Yeomans, 1995). The practicality of this in all four cases was extremely limited. As a result a decision was made to move the focus of my observations to formal multidisciplinary team meetings. The rationale for this shift in focus was based on both practical and theoretical considerations. Having only limited time to spend in the field meant that in order to observe allied health professionals interacting I needed to ensure that I accessed times when this was guaranteed. In all four cases structured multidisciplinary team meetings occurred on a regular basis (weekly in the secondary care cases and daily in the primary care cases). Emergent from data generated from interviews and based on my past experiences I was aware that during formal multidisciplinary meetings professionals discussed patients and through these discussions entered into dialogue as to their involvement in the processes of patient care, their roles and potential boundaries. As with interviews, I was aware of my situatedness within the process of data generation through observation, and utilised this in order to give meaning to my decision making (Gould, 1998). Based on these inferences, the decision to shift observations to formal meetings preserved theoretical consistency (Jeffery and Troman, 2004).

In order to structure and focus the observations, schedules were developed reflecting my research questions and propositions but more importantly were also based on early analysis of the data generated from interviews (Mason, 1996), the underlying assumption being that legitimate links can be made between data generated from interviews to that created by observations (Hammersley, 2006). I also attempted to try and capture the processes and procedures being recounted as well as interactions and negotiations between individuals; the former serving to

contextualise the cases and reinforce or contradict my interpretations from interview data.

Actualising this process of general and specific was at times challenging, In order to provide some structure to my field notes I wrote what I perceived to be different bits of data i.e. process, interactions and my interpretations in different coloured pens. As soon as possible after the event I rewrote my field notes adding to my initial interpretations.

As well as conducting observations of formal interactions I also made field notes during 'gaps' in the time I spent in the research settings. Although no structured observational schedules were used during these gaps, my emergent interpretations of data helped focus my attention upon specific interactions and encounters between study participants. The generation of field notes from non-participant observation raised a number of issues with regards to ethics. Although addressed formally through the processes of ethical applications, working in the field meant that I had to be reflective and responsive to issues of consent and confidentiality, which at times were challenging. A detailed account of ethical considerations related to the research overall will be provided later in this chapter.

Documentary analysis:

Documents generated by study participants as a data source, although identified in my initial research design, did not occur because they did not exist. Across all four cases either respondents or service managers could not identify, beyond generic job specifications or broad KsF¹¹ descriptions, any documents detailing the roles and boundaries of allied health professionals. The intention of utilising documents was as a means of verifying data generated from other sources; however this was not possible (Mason, 1996).

Although not serving as a primary data source, documents were utilised in the construction of the case studies. Web based resources providing details of the types

¹¹ Knowledge and skills framework roles descriptors

of services offered by the health care organisations and the specific services from which the cases were drawn were accessed and interpreted literally in order to contextualise the case studies and to verify or question where possible the respondents accounts and my interpretations.

Sampling units:

The number of units to sample i.e. the number of data sources to access was determined by a combination of reflexive pragmatism (Alvesson, 2002) and the composition of the case studies. These considerations, in addition to the primary unit of analysis i.e. the views of allied health professionals regarding their roles, boundaries and identities working in the cases identified, meant that a number of questions regarding the practice of sampling and selecting need to be made transparent.

The exact number of people and interactions sampled are detailed for each case in chapters 5 and 6. The following discussion focuses on and provides justification for the decisions made regarding the number of units sampled.

The primary sampling units identified were the allied health professionals working in the cases selected for study. Embedded within my methodology is an assumption concerning the classification of individuals specifically that people with the title physiotherapist will have a different role and professional identity compared to someone with the title nurse or occupational therapist. This assumption was furnished from my engagement with the literature and my own experiences as a physiotherapist, but it is an assumption on which key elements of the research are based. This is not to assume that by classifying individuals based on occupation that they are in some way representative of all individuals from that occupation. Again the sampling strategies employed within my methodology clearly restrict the extent to which the findings can be generalised, however, due to the constitutive nature of theory embedded within the entire research process; there is a strong justification for making theoretical generalisations.

In addition to this is the assumption that individuals, although classified as different based on their professional title, are connected in some way because of the physical contexts in which they work. This latter point has already been elaborated on in the context of case studies, however, it again is an assumption embedded within the research questions and underlying propositions.

The second key issue with regards to sampling units is how many units to sample. Sampling with the cases was primarily based on convenience; there were only a small number of allied health professionals working within the four cases which meant that all could theoretically be included in the research. In effect the sampling units occurred naturally and were real life, the extent of manipulation required by me as a researcher with regards to sampling at this level was minimal. Decisions had to be made however as to how many interviews and observations to carry out. Although separated in the composition of my methodological narrative the decision making processes regarding quantity of data were driven primarily by the emergent interpretations and formation of a coherent polyphonic narrative for each case. In addition to this, decisions were also influenced by the practicalities with regards to time and cost, of engaging in data generation (Hammersely, 2006; Depoy and Gitlin, 1998).

To claim that data saturation, interpreted as the data generated providing no new insights (Depoy and Gitlin, 1998), was the driving force behind my sampling decisions or that saturation interpreted in this way was fully achieved I feel would be misleading. I recognise the potential significance of questioning the attainment of saturation with regards to the credibility of my overall interpretations. However, interpreting saturation to be indicative of the ability to construct a narrative which permits meaningful interpretations to be formed, it could be argued that data saturation was achieved across all four cases (Patton, 2002). Through the use of multiple data sources and through cross case analysis structured within the overall extended case methodology, the situated polyphonic narratives resulted in what has been referred to as thick descriptions (Sim and Wright, 2000). In addition to this the involvement of respondents to validate the cases and my overall interpretations adds credibility to the processes of data generation.

In summary, through detailing my data generation methods a number of issues concerning the rigour of the overall research have been brought to the fore. The primary data generation method utilised in order to answer my research questions is qualitative interviews. Although this could be seen as departing from the ethnographic tradition, it is recognised that contemporary ethnography is now seen as eclectic with regards to decisions concerning data generation (Hammersley, 2006). In particular Dicks and Mason (1998) have argued for a 'de-centralising' of observation from ethnographic work in order for this genre of research to fully account of the social. However reliance solely on just one method of data generation raises justifiable concerns with regards to the overall credibility of the outcome of my research. It was for this reason that formal observational and field work data were generated. I regard the inclusion of this data as vital in order to construct a coherent and trustworthy account. I acknowledge that my time in the field was limited; however I feel that my experiences are reflective of the genuine challenges facing qualitative researchers conducting research in healthcare organisations (Sim and Wright, 2000).

Analysis

Analysis as a process involves a 'systematic inductive thought process that clumps together individual items at the specific level into more abstract statements about the general characteristics of those items as a group' (LeCompte and Schensul, 1999, p. 68).

Before giving an account of my analytical approach I feel it important to define and distinguish between a number of key concepts embedded in qualitative analysis, in particular the distinctions between data, analysis and interpretation, which although occurring simultaneously are in essence separate elements within the overall process of analysis.

Data, for the purposes of my research, are the things people say and do during specific contexts identified as being relevant to answering my research questions. With regards to the data generated from interviews the subsequent transcripts could

be seen as 'raw data' (LeCompte and Schensul, 1999, p.3) in that they represent high fidelity accounts of what was said.

It is important to recognise however that the data generated through interview has already been subjected to some degree of analysis, in that through the generation of dialogue both respondent and researcher have been sensitised to a particular research question. In a similar fashion data generated in the form of field notes and observations are done so through the theoretical lens of the research questions (Mason, 1996). The separation of analysis from data generation is a somewhat false one as the two processes are inseparable within qualitative research.

Analysis in its broadest sense could be seen as the process of filtering information in order to generate 'raw data' (LeCompte and Schensul, 1999). When describing processes of analysis many qualitative research texts focus their attention toward the systematic processes involved in sorting, ordering and reducing data generated from for example interviews and observations (Bowling, 2009; Patton, 2002), or as LeCompte and Schensul have described turning raw data into 'cooked data' (1999, p. 3).

In a similar fashion the term interpretation is often removed from the processes of data generation and analysis. Interpretation is seen as advancement on from data that has been analysed. It involves 'attaching meaning and significance to the patterns, themes, and connections that the researcher identified during analysis' (LeCompte and Schensul, 1999, p. 5). Again the dichotomy between analysis and interpretation is similar to that between data and interpretation, in that although delineated in descriptions of research they share a reciprocal relationship in practice (Patton, 2002).

Extending this argument brings to the fore the concept of reflexivity and the often misleading distinction between inductive and deductive analysis and interpretation (Cepeda and Martin, 2005). As already discussed in previous sections of this chapter, I acknowledge that on entering the field my analytical and interpretative frame was formed through my engagement with the literature regarding professional roles and boundaries and through reflecting on my own experiences as a physiotherapist. Articulated as research questions and propositions, my analytical frame of reference sensitised my data generation and analysis, however, as the

processes of data generation, analysis and interpretation unfolded I became conscious of a cyclic migration between the three elements.

It is recognised that no researcher will follow a single analytical approach (Bryman, 2012), and that orthodoxy of critical ethnographic analysis is unachievable.

Accepting this I drew on the work of LeCompte and Preissle (1993) and Lofland (1971), in the development of my analytical approach in addition to engagement with the data. Put simply my analytical process can be described as a series of cyclic stages moving back and forth between low level inferences (coding in vivo) to the development of broader meaning and theoretical understanding. In order to describe the analytical processes I have divided them up into a series of stages, which although presented in a linear fashion often occurred concurrently.

In the field analysis:

LeCompte and Schensul (1999, p. 11) make a distinction between what they term 'in-the-field analysis', which involves the process of recursive analysis, and what could be regarded as the more recognisable processes of analysis and interpretation namely coding, sorting into patterns and themes and generating interpretations. They further break 'in-the-field analysis' down into three separate elements namely inscription, description and transcription.

LeCompte and Schensul (1999, p. 11) have described the recursive process of data generation, analysis and interpretation as 'questioning constantly; getting answers; asking more refined questions; getting more complete answers; and looking for instances that clarify, modify, or negate the original formulation'. Reflecting on my work I was aware that this process was occurring, it felt natural in the dialogues created in interviews or when filling gaps in the field. Taking a point raised by one respondent and then confirming it or discussing it with another felt like the right thing to do. In this sense I was mindful and active in the process of taking what were abstract sociological issues reflected in my research questions and making them ethnographic concerns, whilst at the same time listening and responding to the concerns emerging through the ethnography.

An important point to make clear is that data generation for the two cases drawn from secondary care occurred at the same time; this was also the case for those case studies drawn from primary care. For secondary care data was generated from April 2010 to March 2011. The following year data was generated from primary care (March 2012 to March 2013).

Before commencing data generation in the primary care setting I had completed drafting the case studies from secondary care, a process which included analysis and interpretation of the data from these cases. The significance of this is that on entering the primary care setting I had already been sensitised to concerns and issues which extended beyond my initial research questions. I cannot deny that the timing of the data generation influenced the course of the entire research process. I was conscious of this and attempted to mediate and record this through my reflective diary. I acknowledge that the emergent ethnography is a product of the temporal processes I chose to impose. Although attempting to mediate against this through the process of reflexivity, there is the possibility that through applying strategies which would allow for data generation to occur concurrently across all four cases the interpretations drawn from the cases may have been different. Table 4.1 illustrates, albeit as an approximation, the timing of the processes of analysis for the four case studies.

Table 4-1 Approximate timing of analytical stages for the four case studies

	Case study one elderly rehabilitation	Case study two elective orthopaedics	Case study three Extended primary care Nurse managed	Case study four Extended primary care AHP managed
April – July 2010	Stages one and two	Stages one and two		
August- November 2010				
December- March 2011	Stage three	Stage three		
April – July 2011				
August- November 2011	Stages three and four	Stages three and four	Stage one	Stage one
December- March 2012				
April – July 2012			Stages one and two	Stages one and two
August- November 2012			Stages two and three	Stages two and three
December- March 2013			Stages three and four	Stages three and four
April – July 2013			Stage five	Stage five
August- November 2013				

Tidying up:

Unlike the more responsive and spontaneous processes described for in-the-field analysis, analysis away from the field represented a more structured process and involved moving beyond the data in order to generate interpretations and by doing so locate the case studies within wider sociological frames. In short the analytical process moved from lower level inferences to more abstract interpretations of the data.

In order to make the process of analysis and interpretation I have broken it down into five stages, however it is important to point out the recursive nature of the process overall (LeCompte and Schensul, 1999). The description provided is intended to serve as an audit trail (Krefting, 1991), illustrating the processes of analysis, but more importantly charting and providing a rationale for the stages through which interpretations were formed (Mason, 1996). It is also important to make explicit that the process of analysis involved my research supervisors and the respondents. In the case of the former, the processes and products of coding, interpretation and the use of theory were discussed in order to establish a degree of dependability to my work. For the latter, individual respondents were contacted in order to discuss emergent interpretations. Also, once all the case studies had been written a meeting was held with the allied health professional leads from the two Trusts involved in the research during which key findings and interpretations were fed back and discussed. Both of these activities helped to confirm my overall interpretations. Subsequent to this only minor changes were made to the final case study reports.

The first stage (Appendix A section 1) involved reading and re-reading the interview transcripts and observation notes to identify primary codes. NVivo (version 9) was used to break down the texts into workable chunks of data (Lewins and Silver, 2007). During this process a conscious effort was made to stay as true to the data as possible e.g. via coding in vivo, however, I was aware that some deductive coding occurred (LeCompte and Schensul, p. 60, 1999). As an example an initial starting point for the analysis was an attempt to identify the processes involved in the individuals' day-to-day roles. At a very early stage I was conscious of trying to find out what the respondents did.

The second stage (Appendix A section 2) involved a re-read of the transcripts and field notes and coding without the use of NVivo. Although useful, the first stage of identifying codes through NVivo seemed to not capture the narratives within the data sets. I felt distant from the respondents and the field. In order to combat this I revisited the transcripts in their entirety, again reading and re-reading them but this time having in mind the initial codes that had emerged from the first analytical phase. My primary aim at this point was to better understand the context of the comments made by the respondents. In addition to this I began to broadly categorise the data under the headings of processes, concerns and interactions. By engaging with the transcripts and field notes again I was able to begin to see emergent patterns and contextualise the initial codes, allowing refinement and in some instances re-coding of the data. Examination of the data through the coding process helped to confirm initial coding in vivo, but also led to the generation of new codes based on what the respondents had said/done and as a result new topic areas began to open up. During this process I also began to formulate links and relationships between codes, this was of particular use in relation to gaining an understanding of the processes in which the respondents engaged in their day-to-day work, which fed back into the processes of data generation.

The third stage involved cross referencing the activities of stage one and two, looking for consistency and divergence. The codes were made more robust by my attempts to remain true to the transcripts through the use of coding in vivo and attention to the context of the quotes (Miles and Hubberman, 1984). During this stage, patterns were identified and coding sets grouped in order to form themes and highlight relationships. Appendix A provides a detailed illustration of the analytical process. Although, throughout the analytical process I attempted to view each case study as a separate entity I was aware that during both data generation and analysis I made comparisons between the cases. The comparison of cases and the checking for recurrent themes and categories was an active process as I sought to verify and support the emergent analysis overall (Mason, 1996). This process is particularly transparent in the final two case studies drawn from primary care, where in their descriptions of their work the respondents shared common perspectives regarding elements of their roles and the contexts in which they worked.

Stage four occurred primarily through the composition of the case studies. Through this process I began to organise the data, formalising relationships and structural patterns. All the cases were constructed in a similar fashion. The interpretations of the processes and context facilitated the writing of the 'descriptive' elements of the cases. Moving beyond this, interpretive themes were illustrated by positioning the data so as to provide an interpretative account of the cases in light of the research questions and the emergent themes beyond the initial questions (Mason, 1996, p.137). In composing the case studies the focus was on both the context of the cases as expressed by the data and the praxis of the respondents; the emergent themes providing an interpretive account of their day-to-day through the exposure of the mutual knowledge embedded within the themes

The final stage of analysis is illustrated in chapter seven (cross case analysis). Moving beyond the data and positioning the interpretative themes illustrated in the cases studies within theoretical constructs allowed for the development of theoretical explanations. Through the process of cross case analysis I developed explanations by drawing on theory, the interpretative data from the case studies constituting these explanations. Of significance is the overt utilisation of theory at this stage of the analytical and interpretative process. Through cross case analysis I was able to connect the case studies and reconnect the analysis overall, back to the research questions.

By engaging reflexively with the data and the process of data analysis I became aware that my background as a student of the sociology of professions and as a registered physiotherapist had influenced aspects of the analysis. In order to attempt to make these influences overt I kept a reflective diary and made a conscious effort to record my thoughts as a physiotherapist and a researcher in memos attached to specific codes, categories and relationships.

Topic areas developed through my literature review were the sociology of the professions, professionalism and professional identity. On approaching the data I was acutely aware of the influence my frame of reference had on my initial analysis. Through the process of reflexivity and through discussion with colleagues I have tried to ensure that I made my theoretical influences overt. During the analytical process I attempted to stand back from the data in order to ensure, as far as

possible, I was able to form a narrative from the data, as opposed to structuring the data into a pre-determined narrative. On saying this however, some themes emerged which supported my initial propositions and theoretical frame of reference. As my analysis developed, I was able to move away from my research questions and position them within the context of the cases.

Ethics:

An important element of my development as a researcher has been the recognition of the distinction between ethical issues in their abstracted form and ethics in practice. I recognise the movement from an overtly structured outline of answering my research question as detailed in my NHS ethics applications to, what appeared to me at times, the messy process of what research actually is. It seems apparent that no matter how many texts you read about qualitative research, none can truly capture the details of the research process as much as full immersion.

As with any doctoral thesis one of the first pieces of writing completed was the registration document. As my work involved entering NHS sites and interviewing NHS staff members, at the time the project commenced, NHS ethics, as well as university ethics approval, were required (see Appendix D). Of interest is that shortly after I applied for NHS ethics, the guidelines as to the types of research requiring NHS REC¹² changed meaning that had I applied a year later NHS ethics would not have been required.

The development of my registration document and the production and submission of an NHS ethics form required me to provide, in some detail, the structure and scope of my project. With reference to the NHS ethics application, this included a detailed description of data generation, analysis and anticipated ethical issues. Writing in an abstracted way about my methodology and proposed methods including analysis provided me with a structure on which to base the research process. Although useful, the construction of the ethics applications only addressed those issues that could be foreseen (Angrosino, 2005).

¹² National health Service Research Ethics Committee

Two key issues which were not addressed in the construction of either university or NHS ethics applications were, firstly, the unforeseen ethical issues of conducting field work and, secondly, the more abstract issue of the social and political agendas of sociological research namely the ethics of representation (Anspach and Mizrachi, 2006).

Addressing the first issue, I kept a reflective diary (Krefting, 1991) throughout the duration of the research (including write up), in order to record my experiences of field work, unfolding understanding of the data and analysis, and key decisions made. During field work two situations arose which challenged my position as a researcher and brought into question ethical considerations, more specifically the need to gain informed consent during observations and my role as a researcher in the clinical setting. In relation to the former, although I was able to gain written consent for my structured observations i.e. the formal MDT meetings, written consent was not gained from all staff that I observed informally during my time at the research sites. Ethically I chose to include my observations of informal staff interactions I made whilst filling 'gaps' because; although not to me the individuals concerned remain anonymous. In addition I chose not to record what people said verbatim, but rather to focus in on where and how staff interacted framing this in light of the research questions. My role as a researcher is one which developed over time. On entering the field I made my past experiences as a physiotherapist known to the teams I was working with. I felt it important to be transparent, however I was and remain aware that such disclosure may have influenced how the respondents acted in my presence. On reflection I think that such honesty at the start of my field work for all four case studies facilitated my access to elements of "insider" information. Overall the issues of insider/outsider were evident in my work.

The second point for consideration is concerning the ethics of representation. Throughout this chapter I have tried to demonstrate to the reader that my engagement with the research process has been both critical and reflexive. In order to make my research transparent I have positioned myself, my ontological and epistemological stance within the entire process. In doing this I have attempted to both justify and legitimise my work, contributing both to its validity and its ethical soundness (Gonzalez, 2000; Mason, 1996).

In the construction of the cases and through the cross case analysis I have presented a polyphonic narrative structured from interpretive data and forming and informed by underpinning theory. Referring back to my discussion regarding the construction of the case studies I made transparent the intended audiences and in doing so brought to the fore issues of representation (Anspach and Mizrachi, 2006).

There are broader issues to consider with regard to representation beyond those of simple composition. Although I have made my ontological and epistemological stance clear, I have also, although less overtly, positioned my work within broader academic and political spheres. My research questions and the underlying propositions have been informed by and set against contemporary healthcare policy, and as a result demonstrate an agenda which questions this. A key part of my work is an attempt to link the micro, the lived experiences of individuals, with the macro, the broader socio-political landscape. Such action has been criticised by Smith (1990, p. 14) who argues that by 'transporting the activities of peoples' lives and experiences into the conceptual currency with which they can be governed' serves only to strengthen the ruling apparatus. Although I recognise this stance I would argue that it neglects the role of individual and collective agency in the formation of social structure, and by making links between social action and social structures researchers and respondents are better placed to question these (Jordan and Yeomans, 1995).

Rigour:

A key element of qualitative research is the centrality of interpretation and with this the notion of contingency. Until recently debates around the validity and reliability of qualitative research brought into question the utility of such approaches. Agar (1986), amongst others, has argued that the terms reliability and validity are not applicable to qualitative research, going on to suggest that a different language is required for qualitative enquiry. Criteria such as credibility, accuracy of representation and authority of the writer have been introduced to assure the reader that the overall product of qualitative research is not, as Miles and Huberman (1984, p. 262) have suggested, 'just a well told story'. Stemming from the work of Guba (1981) and Lincoln (1985) a number of writers have detailed issues for consideration

when establishing rigour within qualitative research (Tracy, 2010; Long and Johnson, 2000; Mays and Pope, 2000). Throughout this chapter I have embedded a number of elements which serve to demonstrate to the reader how I have addressed the issues of trustworthiness, namely transferability, credibility and dependability (Krefting, 1991).

Summary:

Throughout the research process the centrality of reflexivity is acknowledged and utilised in order to frame and develop both research questions and methodological approach.

An ethnographic extended case-based methodology, where individual cases are linked through the use of emergent and established social theories, was adopted in order to address my research questions.

The importance of rigour within qualitative research is both acknowledged and addressed throughout the research process.

Chapter 5

Case studies one and two Secondary care:

The next two chapters include the four case studies constituting the findings of the research.

This chapter focuses on the two cases drawn from secondary care. The chapter begins by extending the discussion presented in the methodology, providing details of how the two case studies were selected, and a summary of the data generation. Preceding the two case studies, a physical description of the hospital from which the cases were selected, as well as background information regarding the types of services offered by the hospital which involved allied health professionals is provided. The two case reports are presented separately. The two reports follow the same linear format. The first case report details elderly services. The second case report details elective orthopaedic services.

Identifying the cases:

The time period between January and April 2010 was spent entering the research site and identifying possible cases for study. A number of interviews were conducted with the service managers for planned and unplanned care, and the professional leads for physiotherapy, occupational therapy and speech and language therapy. The purpose of these early interviews was to provide background information regarding the type of services allied health professionals were involved in, and identify possible cases which could answer the research questions. These initial interviews also provided an opportunity for the researcher to become familiar with the process of generating and recording data, as well as an introduction to the analysis process.

In order to answer the research questions and furnish the needs of the extended case-based methodology, suitable case studies needed to provide opportunities where allied health professionals worked alongside one another with the same client group in the same setting. Based on the information provided, primarily by the allied

health professional leads, two services were identified as being able to address my research question; these were inpatient elderly care and elective orthopaedics.

Participant information letters were given to the lead therapists for elderly and orthopaedic services. Through liaison with the lead therapists a time was arranged for an outline of the proposed research to be presented to the teams, after which individuals were provided with written information and consent forms. Interested individuals were asked to contact the lead researcher so that interviews and observations could be discussed. As the data generation proceeded, members of the nursing staff involved in these services were also asked if they would be willing to participate in the study.

Although the hospital had a number of staff identified as allied health professionals working in it, the nature and structure of their work meant that it was only occupational therapists and physiotherapists who worked closely with each other on a regular basis with the same client group, in the same context. The speech and language therapists and dieticians, for example, provided services to patients spanning the whole hospital; they were not bound to a single unit or service and thus had little regular contact with other allied health professionals in their day-to-day activities. Radiographers on the other hand were more bound in their location within the Trust (having specific sites for diagnostic imagery etc), but again, due to the nature of their work, had little contact with other allied health professionals in their day-to-day activities.

A summary of the allied health professional teams and the data generation for the two secondary care cases is provided in figures 5.1 and 5:2

Figure 5.1 AHP team composition and data generation case study one – elderly rehabilitation

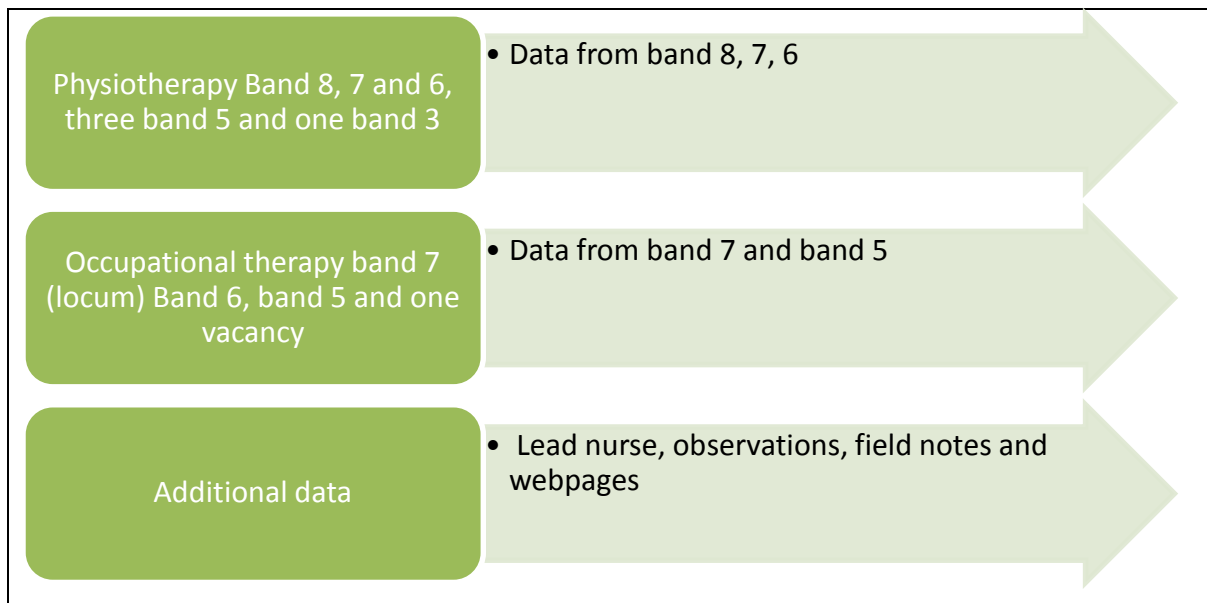
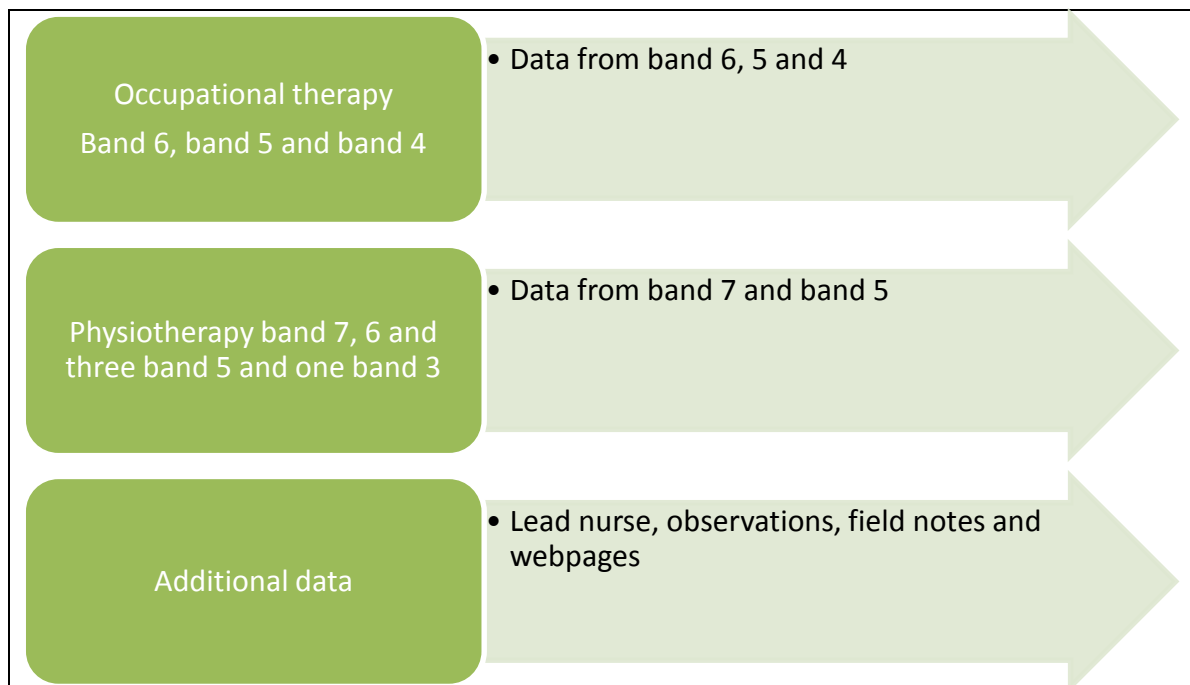


Figure 5.2 AHP team composition and data generation case study two – elective orthopaedics



Data Generation:

Data were generated from April 2010 to March 2011. A total of 16 interviews and five hours of formal observations were completed across the two cases. As well as interviews and observations, field notes were made.

With regards to case study one, elderly rehabilitation, two occupational therapists (Band five and seven) and three physiotherapists (Band eight, seven and six) were interviewed once, each interview lasting over an hour. In addition to this, the ward sister from one of the rehabilitation wards was interviewed (Table 5:1). Non-participant observational data was generated from two hours of observing MDT meetings which involved allied health professionals, nursing staff, doctors, social workers and discharge co-ordinators. Field notes were also made whilst at the study site. Written consent was gained from all staff for all interviews and observations of formal meetings.

Table 5-1 Respondents details case study one – elderly rehabilitation

Respondent	Gender	Employment details	Number of years qualified
Band 7 OT	Female	Locum	10
Band 5 OT	Female	Rotational	1.5
Band 8 PT	Female	Non rotational	19
Band 7 PT	Female	Non rotational	26
Band 6 PT	Male	Non rotational	10
Ward Sister	Female	Non rotational	25

For case two a total of six interviews were conducted with members of staff working in the elective orthopaedic service. Three occupational therapists (band six, five and four) two physiotherapists (band seven and five) and one nurse (charge nurse) were

interviewed once, each interview lasting over an hour (Table 5:2). Non-participant observational data was generated from three hours of observing MDT meetings which involved allied health professionals, nursing staff, social workers and discharge co-ordinators. In addition to this, field notes were also generated. Written consent was gained from all staff for all interviews and observations of formal meetings.

Table 5-2 Respondents details case study one – elective orthopaedics			
Respondent	Gender	Employment details	Number of years qualified
Band 6 OT	Female	Locum	8
Band 5 OT	Female	Rotational	1.5
Band 4 OTA	Female	Non rotational	4
Band 7 PT	Female	Non rotational	15
Band 5 PT	Female	Bank	2
Charge nurse	Male	Non rotational	16

All interviews were conducted in private offices within the hospital. All interviews were recorded and transcribed verbatim. Observational data was gained during formal MDT meetings. The preliminary analysis of the interview data helped structure the recording of data during observations (the development of observational schedules). As discussed in the methodology the timing of the data generation extended over a period of some months. The formal observations occurred once most interviews had been completed. All interviews were sent to participants for member checking and correction. Due to the high turnover of staff at the research site only four interview transcripts in total were reviewed by participants and returned. In order to strengthen the validity of the analysis, case validation was conducted by presenting and discussing the interpretations with staff employed at the hospital once full analysis and case study write up had been completed.

Although stated in the methodology, documentation generated specifically relating to roles and boundaries by either case study were not examined. The reason for this departure from the initial method was that in neither case were specific documents

generated by the allied health professional outlining their practice available, as one occupational therapist working in elderly rehabilitation commented, “we have criteria but it is literally not written down as formal criteria” (band seven OT elderly care). Information regarding the services offered at the study sites provided on the Trust’s website was examined, and in addition to the accounts provided by the respondents and the field notes made, served to contextualise the individual case studies.

It is acknowledged that the lack of inclusion of an additional source of data may affect the overall credibility of the analysis, however, the absence of defined documents making explicit the roles and actions of the respondents illustrates the fluidity of the roles adopted by individual respondents.

Contextualisation of the case studies:

Details of the secondary care Trust:

The secondary care Trust from which the cases were drawn provided primarily hospital based services to a local population of around 240,000 people. The Trust had 4 clinical sites spread across the borough. The Trust’s main site was a large inner city hospital with 379 beds. It was from this site that the two cases were identified.

Opened in 1983 the Trust’s main site offered a range of inpatient and outpatient services including 24 hour emergency services, an urgent care centre, a specialised elderly care unit and a stroke and transient ischemic attack (TIA) centre. The elderly rehabilitation and stroke services were housed in a modern unit which was recently added to the main hospital building. The building itself consisted of a central two storey corridor some 257 metres in length. Crossing this central corridor were six separate corridors, creating 12 blocks in total, each block being a crucifix in shape. Within the 12 blocks were housed the various departments and wards making up the hospital.

Located within the grounds of the hospital was a specialist surgical centre, which provided day and short stay surgical facilities for orthopaedic, gynaecological and general surgery. Opened in 2005 the surgical centre was situated approximately 10

minutes walk away from the main building. The centre had three floors; the first and the second floors housed the surgical and ward facilities. On the ground floor were a modern reception and café area and a number of outpatient clinical rooms

In 2011 new maternity facilities were opened, utilising existing space within the current building. Although having a number of satellite sites located within the borough, the majority of in-patient services were provided from the main hospital site.

Being relatively modern the hospital benefited from the geometric nucleus design, however, even with its recent additions the overall environment placed emphasis on clinical function as opposed to therapeutic or community integration (Gesler et al., 2004).

Patients and staff members accessed the hospital via entrances situated at either end of the central corridor. The central corridor therefore acted as the main thoroughfare through which both patients and staff passed in order to get to their desired destinations. Although all departments were sign posted, the size of the building made navigation difficult, as once inside everything looked similar. The sheer length of the building made it hard to orientate one's self within it.

Service users' demographics:

The inner city borough served by the Trust had one of the youngest and most diverse populations in the whole of the UK, with approximately 40% of the population being under the age of 25. The borough in which the Trust was based ranked as the 4th most deprived areas in London and 11th in England.

Although having a young population, the borough overall had, on average, a lower life expectancy for both men and women, with cases of the common causes of death and long term disability (COPD¹³, CVA¹⁴, cancer and CHD¹⁵) being the highest in England. Data taken from the 2001 census showed that approximately 11% of the

¹³ Chronic obstructive pulmonary disease

¹⁴ Cardio vascular accident

¹⁵ Coronary heart disease

borough's population lived with a long term illness with 50% of these being over 65 years.

Political context

Data generation for the two cases drawn from secondary care was carried out from 2010 to 2011. This was a time when the newly elected Coalition Government began implementing its policies regarding the restructuring of the NHS in England. One key element of the Coalition's policy was to ensure that the NHS as a whole made efficiency savings of £20 billion. All NHS Trusts had to become foundation Trusts. In order to be granted foundation status, NHS organisations needed to meet defined fiscal and governance requirements, a task that not all Trusts were in a position to do. As a consequence a number of hospitals merged and in doing so pooled resources allowing them to meet the requirements. The Trust from which the case studies were drawn was in discussion regarding a potential merger with other trusts. At the time of writing, the type and location of services being provided to the local community remained undecided.

As well as proposed changes in the structure and management of the secondary care services, there were also issues with the employment of allied health professionals by the Trust. At the time data was being generated the allied health professionals working in the secondary care Trust were employed by the local primary care organisation, and then, via a service level agreement, subcontracted to provide hospital based services. Soon after data generation had been completed significant changes were implemented resulting in all those allied health professionals working in the secondary care organisation being transferred via Transfer of Undertakings Protection of Employment regulations (TUPE) from the primary care Trust to the secondary care Trust. Although this transfer occurred after data generation, the staff were aware at the time of the study that such changes were imminent, and as a result were concerned about their current roles and more significantly their future employment.

Allied health professional services within the Trust:

Therapy services:

Therapy services for the hospital came under the directorate of the local primary care organisation. Therapists working at the study site were employed by a local primary care Trust and then contracted into the hospital to provide services. Although overall management for the allied health professionals was located off site, each professional group had a profession specific manager on site to deal with the day to day line management and budgetary issues.

The services offered by the allied health professions were not uniform in structure. The largest two professions (occupational therapy and physiotherapy) had dedicated teams which corresponded to those of the medical services i.e. orthopaedics, elderly, medical and surgical, and neurological. In contrast, the smaller professions, for example speech and language therapy and dietetics, offered a service which spanned the whole hospital.

All the allied health professionals, with the exception of radiographers, providing in-patient services in the hospital, shared a single office area. The therapy offices had been formed from refitting an old ward, and so the offices were open plan with desks and chairs replacing what would have been bed spaces. The offices were accessed by a swipe card security door from the main central corridor of the hospital. Immediately through the door was a staff kitchen, which was no more than a sink, a kettle and two fridges, one marked physio and OT the other SLT. The actual offices were accessed by going down a short corridor, wide enough to fit two beds, and through another swipe card operated door. The occupational therapists and speech and language therapists shared the first open plan office. The physiotherapists had an open plan office to themselves. Dieticians, due to their limited number, occupied a separate office situated away from the main open planned office area. Each office had desks and chairs around the wall and then in the centre of the room also, in addition to the two main open plan offices there were also separate individual offices for the heads of the three services, occupational therapy, physiotherapy and speech and language therapy.

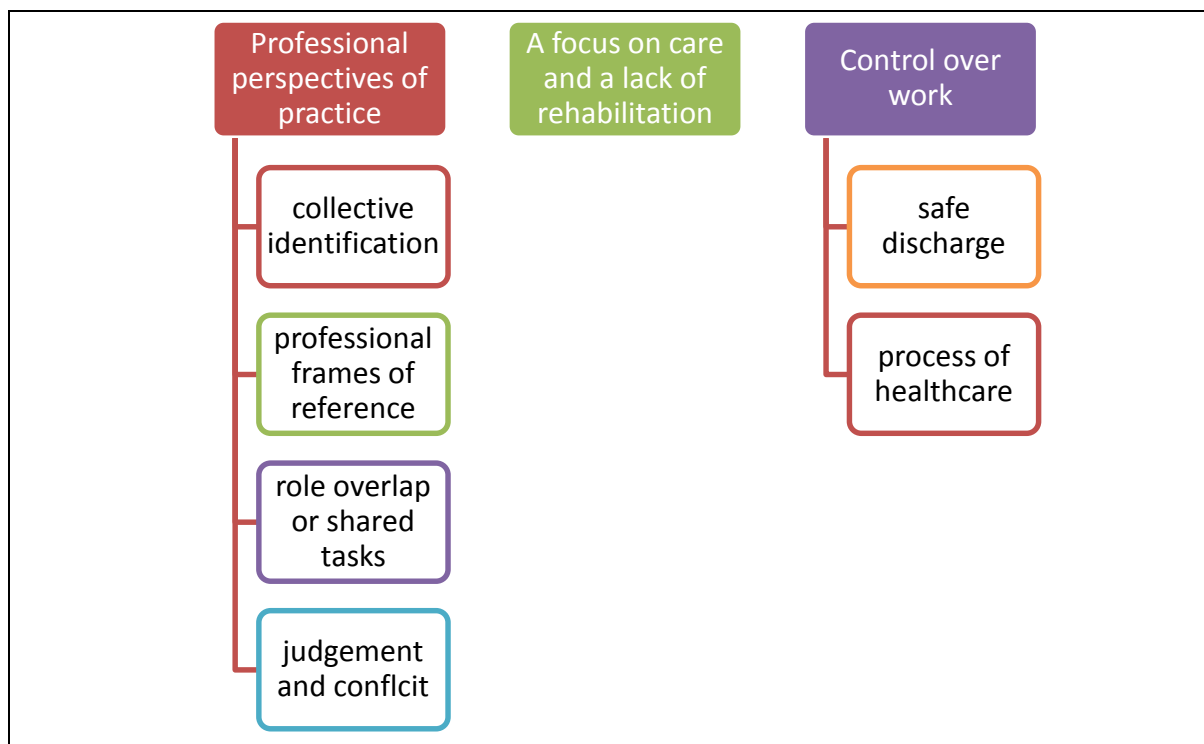
Case study one, elderly care

The format of the case report is an interpretative account of the findings. To begin, an overview of elderly services offered by the hospital is provided. This is followed by a more detailed account of the elderly wards and the work of the allied health professionals on these wards. The latter part of the case report presents the interpretive poly-narrative developed from the data structured under emergent themes.

The study participants were asked to explain what they did in their day-to-day work in this setting. Augmented with observational data and field notes an initial starting point for the subsequent analysis was the identification of the processes involved in the day-to-day. Subsequent granular analysis of these processes highlighted a number of inter-related themes; how and when the therapy staff worked with patients; how their work was shaped by the needs of other professions, in particular the medical profession, and the needs of the Trust. As well as describing their daily routines, the respondents outlined how they felt about working in this setting. Overall the first four stages of analysis outlined in the methodology and evidenced in appendix A, demonstrate the processes involved in constructing the case study.

The following sections will unpack the processes and themes which emerged through the analysis of the data in order to illustrate the complexities of the case in more detail. Three interrelated themes emerged constituting the poly-narrative developed from the data (Fig 5:3). What became apparent during the third and fourth analytical stages was that the respondents' roles and boundaries were interpreted and shaped by a number of interrelated factors.

Figure 5.3 Emergent themes and categories case study one – elderly rehabilitation



The first theme details the respondents' professional perspectives of practice, how this influenced their roles, and the roles of others; the latter point often leading to misunderstandings and conflict. Four interrelated categories constitute this theme.

The second theme to emerge focuses on how the individuals' professional frames of reference helped them position themselves and what they did within the overall management of this client group in this setting.

Finally, the roles of the respondents at times contradicted their frames of reference, this was reflected in how the respondents attempted to create space for rehabilitation and elicit control over what they did. The final theme consists of two categories which detail how the respondents sought to shape their roles within the overall process of healthcare. This final point is demonstrated by the role occupational therapists and physiotherapist played in ensuring a patient is safe to be discharged.

Overview of elderly services:

Although a minority, the elderly population for which the hospital provided services presented specific challenges. There was considerable ethnic, social and economic variation within the elderly population, with a large proportion living in some of the most deprived areas of the borough.

The main hospital site had two elderly rehabilitation wards as well as one ward which provided services to elderly patients requiring hospital admission for acute episodes of illness, but who do not require intensive rehabilitation. It was within these wards that the allied health professionals worked and as a result these areas became the focus of the case study.

As well as providing in-patient elderly services the hospital also offered outpatient services in the form of designated clinics for older people not requiring hospital admissions, but who were under the care of the geriatric medical team. As a whole, the Trust also provided services for elderly patients in the community; these included a falls clinic, intermediate care facilities and long term care which were provided from a satellite clinic away from the main hospital site.

Acute elderly ward:

The acute elderly ward provided services for acute admissions either from accident and emergency or via GP referral. The ward had 26 beds. The ward was split into three bays each bay having eight beds. In addition there were two side rooms for single occupancy. Both bays and side rooms were situated off a main corridor which housed the nursing station, the medications room, the sluice room and a small meeting/staff room. Patient toilets and washing facilities including bath and shower facilities were also situated off the main corridor. Access to the ward outside of patient visiting times was via a security door which was activated via a swipe card. If someone required access outside of visiting times, then an intercom system linked to the nursing station could be used.

Patient accommodation was uniform; all bed stations had a bed, a side table and a tray table. In the bays the beds could be separated via a curtain, however, unless the patient was being seen by a member of staff the curtains were left open. In its design it was clear that the central corridor which housed the nursing station was at the heart of the ward. From the nursing station all bays and both side rooms could be

viewed and it was here that the nursing staff congregated when not attending patients. All bays and side rooms had windows; however, being at the centre of the complex the nursing station lacked natural light, and even in the middle of the day seemed quite dark. The nursing station had phones and two computer terminals and it was here that the medical notes for the patients on the wards were stored. As the central hub of the ward the nursing station seemed constantly busy with lots of people, porters, doctors, therapy staff and nurses coming and going seemingly all the time.

The majority of patients admitted to the acute elderly wards had some kind of acute episode of a long term medical condition. Common conditions treated by the teams included exacerbations of COPD, falls, CVA and Parkinson's Disease. In addition to this the ward also admitted patients with other conditions outside of geriatric medicine. These "*outliers*" (PT Band 6), as they are referred to, could be patients of any age (18+) with any condition requiring hospital admission, although not seen by the geriatric medical team, these patients were treated by the nurses and the therapy staff covering the wards.

Elderly patients would be seen and treated by the medical team, the nursing staff and the physiotherapists, and if required by other members of the team, for example the occupational therapists. The primary focus at this stage of the process was to stabilise the patients' conditions and then to discharge them.

The ward was described by the band six physiotherapist as a "transit ward", in that patients tended not to stay for long periods of time, being either discharged home once their condition had stabilised or being transferred to the elderly rehabilitation wards for ongoing rehabilitation.

In summary, the process of acute elderly services in the hospital centred around the need to assess, diagnose and stabilise patients in order for them to be safely discharged either home, or onto other services.

Elderly rehabilitation wards:

The two designated rehabilitation wards were situated at the end of the hospital on the first floor of a new build. Access to the rehabilitation wards was again from the main hospital corridor. On entering the rehabilitation wards visitors would come to a central waiting area with seating, a coffee machine, a water point and a small reception desk, which during my visits was never occupied. The two wards were accessed from the main reception area either to the left or right depending on which ward was required. On entering the wards, before getting to the patient accommodation, visitors would pass offices and meeting rooms on either side of a short corridor. The individual offices were occupied by the geriatric consultants and the ward matrons; however, these were divided by profession. There were also offices for the medical secretaries who provided clerical support for the medical teams.

Each ward had 24 beds which were grouped in differing sized side rooms running off the main corridor. The largest of the side rooms had four beds the smallest only one. The nursing station was, as with the acute ward, in the main corridor. As a modern build the patient toilet and shower/bath rooms were fitted with assistive devices to facilitate patients' washing and toileting; however of the two bathrooms I saw one was being used as a temporary storage facility for walking aides and commodes.

At the rear of the building the two wards were linked by a communal area which housed equipment used by the staff on the wards, for example blood pressure monitors, hoists and portable suction machines. As well as being a space for storing equipment the communal area also had seating for patients.

The purpose of the elderly rehabilitation wards was, as suggested by the band six physiotherapist, to provide patients with a "*window*" in which to recover and become more functionally independent in order for them to be discharged. The processes described in the acute ward were similar to those of the rehabilitation wards. The focus of both the physiotherapists and the occupational therapists in this setting was to assess for and treat functional issues, the overall aim being to facilitate a safe discharge. Patients on these wards received in-pat from the physiotherapists and where appropriate the occupational therapists.

Although titled rehabilitation, observations of the MDT meetings for the rehabilitation wards outlined a process which mirrored that of the acute ward, where, once

medically stable, patient discharge was the priority. As with the acute ward, the process of elderly rehabilitation was one of assessment diagnosis, stabilise medically and then prepare for discharge, this final point being where the therapists appeared to be most involved.

Staffing:

The physiotherapy team for elderly consisted of one band eight, who had both clinical and managerial duties; one band seven, one band six, three band five therapists and a band three therapy assistant.

The physiotherapists spent the majority of their time on the wards. Their daily routine usually consisted of coming into the therapy office at the start of the day to collect their patient notes. They then went to the wards and joined the day shift nursing staff to take hand over from the ward staff who had been on the night shift. The rest of their day was spent on the wards seeing patients; they were visible members of the ward staff.

The occupational therapy team for elderly was under half that of the physiotherapists. The team consisted of a band seven therapist (locum), who acted as line manager for the rest of the team, a band six therapist and two band five posts, however only one of these was filled.

In contrast the occupational therapists split their time more equally between the office and the ward; in addition they spent a large amount of time off site visiting patients' homes to assess for equipment needs or carry out access visits. Their day was less structured than the physiotherapists and as a result they were less visible on the wards during the day. In addition to this the occupational therapists did not wear uniforms.

Interaction amongst the allied health professionals and with other staff was limited to formal meetings. The acute ward had one ward round a week, the rehabilitation wards two. These meetings were where all staff involved in the treatment of patients came together to discuss patients' progress. As indicated the physiotherapists also

attended daily ward hand over with the nurses. The occupational therapists because of the structure of their day did not. Although the allied health professionals shared an office area they rarely met to discuss patients outside of the formal meetings.

Emergent themes – poly-narrative:

The following section details the emergent themes outlined in fig 5:3

Professional perspectives of practice:

Professional perspectives of practice emerged as a central theme and focuses on how the respondents orientated themselves and their work within the day-to-day of elderly care. A key feature to emerge from the data was how the respondents, when talking about their day-to-day activities, used their profession as a reference point in order to articulate what they did, but also to differentiate their activities from those from other professions. The apparent differentiation between activities along professional boundaries provides some insight into the influence of professional identification on bounding the respondent's work.

Four interrelated subcategories were identified within this theme; these were collective identity, professional frames of reference, role overlap, and finally judgement and conflict.

Collective identification

An interesting aspect displayed by all respondents was the way in which they described themselves and their team by always making reference to their respective profession. "We" when used to describe a group within the wider health care team always referred to the profession the respondent belonged to, for example 'we' the nurses or 'we' the occupational therapists. Although the three professions included in the study worked with the same clients and on the same wards, it was apparent that they did so as distinct professionally identifiable groups, working alongside one another, not as a team.

“Ok, well er so we have got a care of the elderly OT team which consists of myself a locum band seven a band six and a band five, and we should have another member of staff but it’s not filled at the moment” (Band 7 OT).

“ We as in editorial we, I mean physios obviously” (Band 6 PT).

As well as being separate from other professions on their wards the respondents also distinguished themselves as being specific to elderly. Working with elderly patients was regarded by all respondents as being a specialist area within their own professions and as such required different skills and competencies. This difference in identity from colleagues from the same profession working in other areas was highlighted by the nurse who saw what she did as being quite distinct when compared to colleagues working on general medical wards for example.

“So actually from the admission to the discharge we get involved, erm, personal care here, which is different in like medical ward or the acute medical ward” (Ward sister).

Through defining their orientation towards the patients the respondents were able to give meaning to what they did as a professional, this process also served as a means of differentiating their work from colleagues from other professions in the same context or the same profession in other contexts.

Professional frames of reference:

In talking about their day-to-day activities, all the respondents made reference to their profession through the use of accepted models of practice or definitions from within their profession in order to explain what they did in this context. By doing this the respondents framed their practice and situated it within the overall management of this client group in a way that was unique to their own profession. What was evident however was that the degree to which the three professions felt they ‘fitted’ into the overall management of patients in this context differed , and in the case of the occupational therapists led to a disjuncture between their professional frames of reference and the roles they occupied.

“if we were to compare how it was, how it is now to what, all the theory and lovely models and philosophies that we had going through university, I think it would be very different, given that the resources that we get told about in university aren’t actually there in reality! So yes, umm the barriers I guess as well, the pressure for discharge” (Band 7 OT).

All respondents acknowledged that there was a clear difference in focus between their professions when working with patients in this context; this was exemplified in their assessment but also in their overall approach to patient care.

The nurse saw her role (and that of her team, i.e. the nurses) as addressing all aspects of the patients’ experience whilst on the ward. Unlike, in her opinion, the physiotherapists and the occupational therapists; the nurse saw her role as working with the patient when they were unwell to when they were able to do more for themselves, and justified her work with reference to established models of nursing practice.

“we enable patient from when they are not very well, so somebody with pneumonia who cannot do a lot, who is very sick, on anti-biotic and erm, so we maintain what we call the activities of the daily living breathing, communication, eating, drinking personal care elimination, up to care of the diet so we follow you know those 12 processes, that is what we do” (Ward sister).

Justifying her work in this way helped the nurse anchor her day-to-day as well as distinguish her role from that of other professions.

In a similar fashion, the physiotherapists anchored their day-to-day by framing their work within concepts embedded within their profession. Unlike the nurse, the physiotherapists’ focus appeared for the most part, to be more narrowly defined. Although not referring directly to a specific model of practice, all the physiotherapists interviewed defined their work with patients within the context of functional rehabilitation, for example by improving the patients’ ability to transfer or mobilise, the aim of which was to reduce risk and facilitate a safe discharge from hospital. The physiotherapists were in agreement that their work reflected the focus of their profession in that they were aiming to help the patients become more functionally

independent. They saw their work as addressing the needs of the patient (enhancing independence) and of the wards (facilitating a safe discharge), and that through their input they were able to position their work within the overall management of the patients in this context.

“so we treat them, some of them are discharged home from the ward some are discharged from the acute ward to the continuing rehab ward that is the other two wards and from there then they are treated and then they are discharged home, now discharge may take the effect of, yes the patient is good enough to be discharged straight home independently, person is good enough is going to be discharged home but will need continued, emergency care, which would normally be the home rehabilitation team service, or they may just require normal continuing physio rehab so they go to the community physio or they may not be safe to go back onto their own and they need social services involvement where carers have to be organised so then we could say ok, are they going home with the social services involvement or are they going into a warden controlled area or are they going into er, into a nursing home so you have to look at all that” (Band 8 PT).

Although acknowledging that their focus was primarily on physical function, the physiotherapists also indicated that a key element of their work, and one which distinguished them from physiotherapists on other wards, was the need to address the psycho-social needs of the patients. This more holistic approach was seen by the physiotherapists as the area where they most overlapped with other professions in this context. In light of this, the view held by the nurse that the allied health professionals did not see the patient in a holistic way is challenged and brings into question what is meant by the three professions by holistic care. The nurse defined holistic as being with the patient throughout their stay on the ward (from ill to ready for discharge). The physiotherapists by their own admission only worked with patients when the patients were medically stable enough to engage in physical rehabilitation, however, still saw their work as an expression of holistic care in that they acknowledged and incorporated the psycho-social needs of the patient into their patient encounters.

Emergent from the data is that, although utilising the same terminology, the respondents, by drawing on different frame of reference, interpreted their work and the work of others outside of their profession differently.

In contrast to the physiotherapists and the nurse, the occupational therapists found it hard to frame their day-to-day work within their view of occupational therapy. The focus of the occupational therapists' work in this setting was to facilitate a safe discharge primarily through the provision of equipment or the setting up of packages of care, however, this was not congruent with what they had been taught at university, or what they felt was at the heart of occupational therapy.

“Well yes, yes, but I’m not sure to what extent like, compared to other things and patient centred care I don’t know you know if it’s not something, it’s a balance it’s more of a balance, I feel that the hospital setting, working in a hospital setting the focus is more on safety, erm, as opposed to may be maximising independence and say quality of life you know because that’s, may be something that the community teams can continue to do so, erm yes” (Band 7 OT).

The band seven occupational therapist felt that by working in the hospital setting for an extended period of time that her focus had “shifted” from one which reflected occupational therapy to one which reflected safety and discharge planning. What was clear from all the occupational therapists was a feeling of frustration and a lack of professional fulfilment as they were unable to practice in a way that reflected their profession.

In order to give meaning to their day-to-day work the respondents had to be able to produce a synergy between their professional frames of reference and other frames of reference in operation within the context in which they were working. Break down or conflict in these frames of reference led to frustrations and a lack of professional fulfilment.

Through defining their roles the respondents claimed jurisdiction over certain areas of patient care. For the nurse this was broad, something which her professional frame of reference was able to accommodate. In contrast the allied health professionals had a narrower frame of reference, in the case of physiotherapy it

focused on functional ability and for occupational therapy facilitating a safe discharge though the provision of equipment or packages of care. Although for the latter the congruency between role and professional frame of reference was clearly challenged.

Role overlap or shared tasks?

Although the respondents were able to distinguish their day-to-day work from colleagues from other professions they all acknowledged that there were elements of their work which overlapped. For example in the case of the nursing staff and the occupational therapists there was overlap with facilitating a patient to wash and dress or ordering equipment at discharge, or across all three professions, with regards to the facilitation of transfers and mobility. Although overlap was apparent distinct roles were created through the interpretation of and meaning attached to the common tasks they performed.

“What we are supposed to be doing, erm, I do, I do because erm, they (the physiotherapists) will do the assessment they have a lot to write about and they check is the patient is in pain, you know the joint and, which the nurses don’t, we the trained nurses do because if they are in pain you know we give them medication, and the junior staff if they tell us they are in pain then we give them so, but physio is more, the assessment is more detailed than what we do” (Ward sister).

This is further illustrated by the band five occupational therapist when describing working on transfers; she explained that even though she may be doing the same task as a physiotherapist the focus of the two professions and the meaning attached to the activities differed significantly.

“you’re looking at different things and you’re looking at the same thing but you have got these two pairs of eyes and from different perspectives” (Band 5 OT).).

Which tasks were emphasised and which were neglected, and how these tasks were interpreted, was a direct reflection of the respondents’ professional frames of reference. These interpretations also extended beyond the ward. Depending on whether or not a patient had had input from the AHP teams, determined to a degree

the recommendations made at discharge planning meetings and the subsequent support offered to patients once discharged. Such variations would not in principle matter if all patients received AHP input, however what was evident from the data was that this was not the case. Overall, the meanings, the interpretations of the tasks performed by the different professions with patients, were a product of their individual professional frames of reference. It was through these interpretations that roles were defined and distinguished.

Judgements and conflict:

The importance of these different interpretations of commonly performed tasks become apparent in their production of barriers to, and conflict between, the professions. The differences identified in the respondents' professional frames of reference led to problems with communication between the professions. So, for example, the physiotherapists placed more emphasis on the patients' ability to transfer out of bed independently, whereas the occupational therapists facilitating the same task placed emphasis on how the patient would cope, once discharged, in performing this activity. Similarly, in describing the assessment of a patient's ability to wash and dress, one occupational therapist commented that a nurse's interpretation of needing assistance to wash differed considerably from that of an occupational therapist. The result of which meant that the occupational therapist may provide less assistance whereas the nurse may provide more.

“nursing staff saying oh yep they need assistance with washing and dressing ok, and we would be like ok is that assistance of one person or is it assistance of two people, oh yes assistance of one, is that quite a lot assistance are you getting, are you using quite a lot of your energy, or erm, is it just a little bit, a little bit of fine prompting or physical cueing or is setup, is just setting up the environment, set up assistance without any physical contact or, is it verbal prompting or yes, just really kind of establishing how much hands on assistance is required or, is it something that you need, you need to assist the patient in initiating and then they can then complete it” (Band 7 OT).

These differences in focus and meaning between the professions may be responsible for the respondents' candid reports of conflicts between the professions in this setting. The delineation of tasks along both professional and organisational

frames of reference allowed the respondents to position their work and distinguish it from others. However in doing this, they made claim to specific aspects of the system of care. Breakdowns in perceived obligations attached to these claims led to conflict. This is exemplified in the task of transferring a patient out of bed. Although the nursing staff engaged in this task, they viewed it as being the role of the physiotherapist and as a result expected the physiotherapists to do it regularly. In contrast the physiotherapists saw their role as assessing the patients' ability to transfer out of bed and then to provide exercises to enhance this. Although the task was similar the differing meanings attached to the task, meant that roles were created and boundaries drawn.

“physiotherapists, their assessment is different from ours, well we used to have like, I wouldn't say problems, more like misunderstandings, er, nursing staff would think er, if they can't do anything with the patient its physio's responsibility” (Ward sister).

“all the patients are seen by the physio and the nurses tend to depend on us a bit too much for erm, waiting for us to sort of get them out of bed”(Band 8 PT).

A focus on care and a lack of rehabilitation

The second theme to emerge from the data was the reported lack of rehabilitation offered to patients in this setting. It was clear throughout the data that there was greater emphasis on caring for patients as opposed to rehabilitating them. Although there were designated wards for acute admissions and rehabilitation, the rehabilitation wards served primarily as an overflow for the acute elderly ward, admitting patients who were often acutely unwell or whose discharge had been delayed due to complex social issues.

“often erm the patients who are on the rehab wards aren't actually appropriate for rehab in the first place because they're being sent there as a, to wait for their, to wait for a nursing home placement or to wait for a transfer to another hospital or something, so it's really just another use of a bed” (Band 7 OT).

“they are sending people from five days from the acute ward, so they are still quite acute still quite ill, so they, I know that they are very busy and that they are spending so much time with the ill people to actually get someone to walk to the toilet to have a shower or a wash in the morning, its easier for them to give a bed bath you know what I mean. Its very time consuming to wait for people to do things for themselves, yes I can see why they don’t have the time” (Band 7 PT).

A consequence of this was that although these patients had been identified as having rehabilitation needs the work of the allied health professionals mirrored that of their colleagues on the acute ward, their focus being on addressing the acute medical needs of these clients and facilitating a safe discharge.

The often complex medical needs of the patients on the rehabilitation wards served to legitimatise the need for ongoing medical and nursing care.

The band five OT felt very strongly that the lack of rehabilitation and the privileging of care in this setting often meant that patients deteriorated as opposed to improved.

“what seems to happen in there, in my little experience, is that generally people that, people seem to be deteriorating, they are becoming incontinent and I think that that is a whole staffing issue because, you know if there are not people there to take them to the toilet when they want to go and you know things like that so it’s, and then people spend more time in bed and then they ever did and because its rehabbing and it’s over a period of weeks often they are in bed more than they are doing much else, I think it is just the nature of, of what it is, it doesn’t feel like a rehab ward to me not at all” (Band five OT).

The occupational therapists in particular stressed that their work in this context involved little if any rehabilitation, their primary and often sole focus was to facilitate a safe discharge for the patients.

“in this acute setting it is, erm facilitating a safe discharge, but there is this idea of this rehab ward and so often we get a referral for a patient who is going home in the next, or there is a discharge set for planned for the next couple of days and so between the time of referral and the time they go home there is absolutely no rehab that goes on in that time because the discharge

planning takes up all of that time, er, so yes it ends up being, in an acute setting facilitating a safe discharge, umm, and with referral onto service which can carry out the rehab in the patient's own home or where ever it may be" (Band 7 OT).

Although the physiotherapists echoed this view, when questioned directly if their role was to engage patients in rehabilitation, both physiotherapists who worked on the rehabilitation wards (Band 7 and Band 8 PT) argued strongly that rehabilitation was a central part of what they did. They viewed rehabilitation on a spectrum of functional activities, they valued their input in that it meant that patients would be able to function at a safe, but basic, level once discharged. However, they acknowledged that the process of rehabilitation was something that needed to continue once the patients were in the community setting.

The lack of opportunity to engage patients in prolonged rehabilitation beyond that of being safe for discharge led both groups of allied health professionals to place emphasis on the need for rehabilitation to continue, or in the case of occupational therapy begin, in primary care. In doing so the allied health professionals were able to reconcile the potential conflict between their professional frames of reference and the context in which these were being utilised. This process of reconciliation was further evidenced by the allied health professionals suggesting that hospitals were not the best place for rehabilitation, hence the need for a rapid discharge. Issues such as a lack of time and resources to effectively engage patients in rehabilitation, in addition to the recognition of the pressures on beds and the risks of prolonged hospital stays were cited by the allied health professionals as a means of supporting the need to discharge patients rapidly.

In summary, what was apparent was that the primary focus was to manage patients medically and care for them until they were well enough to be discharged. The ethos of the organisation was reflected in the work of both the nurses and the allied health professionals. One of the respondents, a physiotherapist, who had been working in the NHS for over 30 years, offered an interesting insight into how the focus of secondary care had changed in the past 10 years. In the past patients admitted onto rehabilitation wards were there exclusively for rehabilitation. Rehabilitation wards

rarely had medical cover the wards were nurse led and so the patients had to be medically stable before being transferred there.

Control over work:

The final theme developed from the data focuses on how the respondents, in enacting their roles, attempted to exert control over what they did. Two interrelated categories formed this theme. The first focuses on the central aim of the respondents in this setting as being directed toward ensuring a safe discharge. By drawing on the discourses of safety the allied health professionals sought to influence their work and the work of others. The second category illustrates how, through the processes and structures of healthcare, the respondents again sought to control their day-to-day work.

A safe discharge:

What was clear from the data was that once the patients' medical conditions had been addressed, the whole process of input moved to discharging the patient as rapidly as possible. The dominance of the medical profession in this process was clear. As soon as a patient was admitted onto the wards the first thing discussed was the predicted discharge date. This date centred on the estimations made by the medical team regarding the likely time needed for the patient to recover medically. This date bound the work of the allied health professionals by placing a time frame in which they could complete their tasks helping the patient to be as functional as possible. However, it was not until patients were medically stable that they could engage in rehabilitation and as a result the focus of the allied health professionals' work centred on ensuring that patients were safe for discharge.

“I think as soon as, as soon as the doctors say that somebody's medically fit and they want them home if they're needing assistance of two then it's a manual handling risk so they need a hoist, but they might not need assistance of two, most of the time they might need assistance of one but occasionally they might need assistance of two but, it's always like that's the sort of quick option, you know that's the safest thing the carers have got the hoist and that's it and I think social workers are a bit like that as well “ (Band 5 OT).

Although the discharge date was determined largely by the medical profession, the allied health professionals, through their focus on a safe discharge, were in a position to influence the decision making processes of the doctors. Through the discourse of safety, the allied health professionals could influence and in some cases determine the length of stay of patients on their wards, or the level of support patients received once discharged.

“if the OT made a recommendation and said oh well this person or physio it could be a joint decision, oh well walks with a zimmer frame but still unstable or it is something to do with kitchen assessment, you know unable to make a cup of tea, and they go home try to hold the frame and try to make cup of tea and they fall then people would think oh well because they didn’t listen to what we said, so yes they are scared of, yes, many times you get patients and family shouting at you do it, oh well my mum can’t go home because she is not safe, so you get that as well, everything we do will be oh well what will people in the family might, oh well if you do this you might get complaint oh well why did you do that, but is not what we actually think all the time but especially safety, especially falls yes, or someone who you might think that wanders a lot who opens the door in the middle of the night and walks the street, so it is not all patients” (Ward sister).

The process of healthcare:

In addition to the discourse of safety another means by which the allied health professionals sought to communicate a degree of control over their work was by rationing their services.

It was clear from the nurse interviewed that she regarded the nursing team as being at the centre of what was happening on the wards. nurses were with the patients 24 hours a day and as such had access to their day-to-day lives within this context. The nurse said that due to this proximity the nurses were in a position to control what happened to the patients.

“so we actually are at the centre of looking after the patient, then we use other disciplines in achieving our goals” (Ward sister).

This control extended to determining whether the patients were seen by the allied health professionals or not. This control was structured through a formal referral system. Patients requiring allied health professional input needed to be referred by either the doctors or the nurses. The referral system was linked to the allied health professionals’ activity monitoring and so was used to determine the yearly budgets and staffing levels for the allied health professional teams. Through this formal system of referral, the nurses and the medical team were in an apparent position of power, as they could in effect determine who was or who was not seen by the allied health professionals.

Two of the physiotherapists interviewed said that they assessed all new patients who came onto the wards regardless of whether a referral had been made or not. The rationale for this was provided by one of the senior physiotherapists as:

“Just about everybody needs, there are very few that come I can say you know are up walking, good balance and they don’t need anything” (Band 7 PT).

The physiotherapists chose who they saw depending on the outcomes of their assessments. However, the physiotherapists were aware of the implications of not having a formal referral in place. As a result the physiotherapists instructed the nurses to refer patients if, after their assessment, they thought they needed physiotherapy input. In addition to this, by having assessed all patients, the physiotherapists had a good knowledge of who was on the wards and used this during the formal ward meetings as a means of contributing, or not, to the formal discussions thus embedding themselves within the team.

In contrast to the physiotherapists, the occupational therapists only assessed patients that had been referred to them. The occupational therapists acknowledged that not all patients on the wards would need occupational therapy input, and so by utilising the formal referral system in order to access patients they were in a position to limit the number of patients they saw. In addition to this the band seven occupational therapist screened all the referrals before accepting them, again as a

means of controlling who her team accepted. The band seven occupational therapist said that she had to be “very careful” as to whom she accepted onto the teams’ case load, as occupational therapy input was in her view very labour intensive and she had limited resources. Through this screening mechanism the occupational therapy team placed themselves in a position to ration their services.

“you know we have to be quite erm, we have to screen, we have to screen our referrals therefore, erm because as soon as we agree to take a referral on or to accept it then we have our duty of care to make sure we carry out a thorough comprehensive assessment, so, we need to be very careful about who we are accepting and who we are not and making sure that they meet the criteria” (Band 7 OT).

However, by only seeing patients referred to them and not screening all patients admitted onto the ward, the occupational therapy team had a list of patients waiting to receive their service. One outcome of this was that an aspect of the band seven occupational therapists role involved screening and managing the waiting list.

“Oh yes, ok sure rapid turnover or that we don’t get the referral until it is too late, erm because it’s not a blanket referral system er, we do get quite a lot of inappropriate referrals and time spent screening and attending to all the documentation required to, when you do receive a referral is again I guess time that is wasted that could be used in, more effectively with the patients that we actually have on our list and are appropriate for our service at the time, so that’s is something that we are struggling with at the moment “ (Band 7 OT).

Unlike the physiotherapists who had contact with all patients on the ward, albeit in some cases limited, the occupational therapists only knew of those patients who had been referred to them. A consequence of this was that during the formal ward meetings the occupational therapists were often unaware of whether a patient needed their input or not and so were unable to contribute fully to the patient discussions. A more significant effect of the reliance on other professions for accessing patients was that the occupational therapists often only received referrals once a patient was ready to be discharged and as a result had only a limited amount

of time, the focus of their work therefore being directed away from rehabilitation toward facilitating a safe discharge.

“so yes it really comes down to erm, discharge planning, effective discharge planning, and very quickly because of the staff capacity we often spend our time facilitating discharges as opposed to carrying out rehab” (Band 5 OT).

Summary:

The emergent interpretations from the case study indicate a complex process of care in which allied health professionals' roles and boundaries are shaped and enacted. A central element for the allied health professionals is their ability or not to position themselves and their work within the overall management of patients in this context. Of importance is the degree of synergy felt by individual professionals between their professional frames of reference and the roles they occupied. Where disjuncture arose individuals were able to reconcile and give meaning to their roles by drawing on the discourse of safety.

Case study two: Elective orthopaedics:

The format of the case report follows that of the first case study. Firstly an overview of orthopaedic services in the hospital is presented, followed by an overview of elective orthopaedics. The latter part of the case report presents the interpretive poly-narrative developed from the data structured under emergent themes.

The orthopaedics services offered by the Trust included both inpatient and outpatient services. The hospital had one elective orthopaedic ward and one trauma ward. The allied health professionals involved in the study made up a service which covered both wards. The orthopaedic team consisted of six consultant surgeons, surgical staff, specialist nurses, physiotherapists and occupational therapists. The team provided a range of orthopaedic services including day surgery, paediatrics, trauma and elective surgery. The team had weekly MDT teaching sessions.

Based on discussions with therapy and nursing managers, it was decided to focus on only one of the in-patient orthopaedics services. The elective orthopaedic ward treated patients who required planned hip or knee replacements. The age range of the clients on this ward was a little younger than on the elderly wards studied, however, this client group required ongoing rehabilitation once discharged from hospital and therefore there was an empirical link to the case studies selected in primary care.

As for case study one the respondents were asked to describe their day-to-day work with this client group in this context. All allied health professionals interviewed worked across both elective and trauma orthopaedics; however they were asked to talk specifically about their work within elective orthopaedics. The nurse interviewed worked only on the elective orthopaedics ward. In addition the formal observations were of MDT meetings for the elective ward.

A number of inter-related themes emerged through the analysis of the data. The data generation and analytical processes mirrored those described in the first case report (Appendix A). In building the foundations for the extended case method applied analysis did involve the recognition of common themes and categories. In saying this, however, attention was given to the complexities and uniqueness of the

respondents' descriptions of their day-to-day. Through the cyclic process of analysis both the meanings and processes, as recognised and demonstrated by the respondents working with this client group in this setting, were captured.

Two interrelated themes emerged from the data. The first theme centred on professional perspectives of practice and had four categories which both mirrored and contrasted the findings from case study one. The respondents reinforced the findings from the first case study through their recognition of a profession specific collective identity and frame of reference. In contrast to the first case study roles and boundaries were not contested. Unique to this setting also was the way in which the respondents gave meaning to their work. Emphasis was placed more on their relationship with clients as opposed to their profession specific knowledge and skills as a means of defining roles.

The second theme to emerge from the data highlighted the extent to which the respondents felt they had control over what they did, and how their roles were in part a product of the needs of the medical profession and the organisation as a whole.

Figure 5.4 Emergent themes and categories case study two – elective orthopaedics



In patient Orthopaedic wards:

The elective orthopaedic ward was situated away from the main hospital in a new building (opened October 2005), which also housed renal services. The orthopaedic ward was on the second floor of the three storey building. The building itself was a standalone treatment centre equipped to provide elective day and short stay surgery. Capitalising on recent advancements in hospital design, the building featured a number of physical aspects to facilitate health care delivery which took into consideration the patient journey as well as offering an aesthetic and environmentally conscious space. In its design, emphasis was placed on creating a therapeutic space in order to aid recovery. Clinically the building had all the facilities needed in order to provide effective care in one place (www.nhs-procure21.gov.uk).

The ward had a maximum capacity of 30 beds but at the time of data collection only 18 beds were being used for orthopaedic patients the rest were used for oncology patients. The ward did occasionally take trauma patients, but only those who required active rehabilitation.

At the entrance of the ward was the main reception/nursing station where the patients' medical notes are kept. The ward clerk was based at this desk and acted as both clerk and receptionist for the ward. Behind the reception area was the ward and nursing offices.

The ward was a mixture of single rooms and bays which had between three to four beds in each. The bays were single sex. All rooms and bays were situated off two parallel central corridors which ran the length of the building. At the end of the corridor was a small gym area with a range of exercise equipment. Although there was a gym there were no specific occupational therapy areas other than an accessible bathroom. A consequence of this was that if the occupational therapists wished to assess kitchen activities, for example meal preparation, then they had to take the patients across to the main hospital building.

Patients were admitted on to the elective orthopaedic ward for pre-planned surgery, this being either total hip or knee replacement, both of which required a short period of hospital admission (between five-seven days), or for day surgery, for example anterior cruciate ligament repair. As the unit was elective both the patients and the staff knew when patients would be coming into hospital. Another significant issue was that in order to be admitted for surgery they had to be medically well. In contrast to the elderly wards the medical, nursing and therapy input for the patients was routine in that the treatments (either hip or knee surgery) were standardised. This standardisation included length of stay in hospital, assuming the patients did not suffer any post-operative complications. As a result the level of input from the medical team both prior to, and post-surgery, was minimal. This notable difference in comparison to the elderly wards meant that the post-surgical care for patients was primarily nurse and therapy led.

Occupational therapy and physiotherapy had designated teams to cover the elective and trauma wards. The occupational therapy team covering orthopaedics comprised one band six locum therapist who, as well as seeing patients, acted as line manager

for the rest of the orthopaedic occupational therapy team; one band five therapist and a band four therapy assistant. The physiotherapy team was larger, consisting of one band seven therapist, who, like the band six occupational therapist, had managerial as well as clinical responsibilities, a band six therapist and three band five therapists, in addition to this the physiotherapy team also had a band three therapy assistant. Although both teams' primary responsibility lay on the orthopaedic wards they also saw patients who were under the care of the orthopaedic consultants but were placed on other wards within the hospital. For the physiotherapists, this meant seeing patients in A and E and on the paediatric wards.

The physiotherapists' day mirrored that of the colleagues in elderly services in that they spent the majority of their time on the wards. Their daily routine usually consisted of coming into the joint therapy office at the start of the day to collect their patient notes. They then went to the wards and joined the day shift nursing staff to take hand over from the ward staff who had been on the night shift. The rest of their day was spent on the wards seeing patients. However due to the scope of the physiotherapists' input across the hospital site their days were often fragmented due to having to see all orthopaedic patients including emergency cases in A and E.

The occupational therapists split their time between the joint therapy office and the ward; in addition they spent a large amount of time (approximately a 3rd) off site visiting patients' homes to assess for equipment needs or carry out access visits. Because they knew who would be coming for surgery, the occupational therapists carried out home visits before patients came into hospital. This allowed the occupational therapists to prepare the patient for discharge before they had been admitted.

The occupational therapists, the physiotherapists and the charge nurse ran joint patient education sessions for patients before they were admitted. These sessions involved explaining their respective profession's role both pre and post-surgery and answering any questions which often included explaining the surgery itself. What was evident in this case was that the involvement of the medical team in the treatment of patients did not extend much beyond the operating theatre and that the majority of patient care was managed by the nurses and the therapists. In addition,

because the patients' care was standardised there was little variation in the day-to-day work of the allied health professionals.

Interaction amongst the therapists was proactive. The occupational therapists and physiotherapists took advantage of having shared office space, and were regularly seen discussing patients away from the ward. Interaction with the nursing and medical staff was restricted to more formal meetings. The elective ward had one ward round a week. These meetings were where all staff involved in the treatment of patients came together to discuss patients' progress. As indicated the physiotherapists also attended daily ward hand overs with the nurses. The occupational therapists, because of the structure of their day, did not always attend these meetings.

Emergent Themes – poly-narrative:

The following section details the emergent themes outlined in fig 5:4

Professional perspectives of practice:

Collective identity:

The respondents recognised demarcations between their professions. In describing their work, the respondents made reference to their profession specific teams and in doing so exhibited similar collective identity as exposed in the elderly care case. The respondents worked with the same clients on the same ward, but did so as distinct professionally identifiable groups, working alongside one another.

Similarly to elderly care, the respondents working in elective orthopaedics also distinguished themselves from colleagues from the same profession working in other areas within the hospital. The importance of context with regards to shaping and refining the respondents' professional frames of reference was exemplified by the nurse. He acknowledged that his professional frame of reference had changed since working on orthopaedics. He recognised that nurses working in other wards with different client groups may not recognise his work as fitting into the traditional view of a nurse's role.

Through defining their orientation towards the patients, the respondents were able to give meaning to what they did; this process also served as a means of differentiating their work from colleagues from other professions or colleagues from the same profession working in other settings.

“we should look at having some sort of extra training which is more focused on the rehabilitation part. But as a general nurse, you have the basic knowledge but I don’t think its in-depth and I also don’t think we should include it in general nursing, because it’s quite a specialist area. But certainly is somebody is working on an orthopaedic ward, then part of their personal development is to be able to do a further training, to look at rehabilitation; because it is important (Charge nurse).

Clearly defined roles based on process of care:

All the respondents were able to define the roles of their colleagues from the other professions in a consistent way. They knew what each other did. For example descriptions of the role of the occupational therapist provided by the occupational therapists were echoed by the physiotherapists and nurse when asked to detail the role of the occupational therapist. It was clearly evident from the respondents how each profession fitted into the overall process of patient care.

“everybody’s got a very clear role for the elective it’s that oh the OT the equipment should be in the OT will do a quick transfers the physios know their role erm they’re mobility and transfers, erm there might be a little bit of cross over working sometimes but less often I’d say just because the roles are more clear, you know what you’re doing” (Band 6 OT).

The boundaries formed between the three professions outlined clear jurisdictions in the process of patient care. The physiotherapists’ primary role focused on assessing and restoring a patient’s mobility to the point at which they would be safe for discharge. This involved working on functional tasks such as transfers, mobility, prescribing exercise and addressing balance issues. In contrast the occupational therapist’s role focused on assessing the patients home prior to their admission and

where necessary issuing equipment in order to ensure a safe discharge. The nurse saw his role as managing the day-to-day experiences of the patients whilst on the ward. What was clear from the data was that the standardisation of the patients' care meant that the roles occupied by the nurse and the allied health professions were clearly defined and transparent, and as a result the issues of conflict between professions were not evident within the data. The transparency of roles between the professions was enhanced by the joint patient education sessions run as part of the overall service. This provided the respondents with a space in which to make clear their role within the overall management of the patients.

Professional frames of reference:

Although influenced by the process of patient care, the jurisdictions occupied by the three professions reflected the unique knowledge and skills each profession brought to the process. The specific knowledge and skills brought to the process of patient care were evident by the respondents' descriptions of their work but also through their recognition of the roles of their colleagues from other professions. For example, the nurse interviewed was quite aware that there was more to occupational therapy or physiotherapy than issuing equipment or mobilising a patient.

“occupational therapy is more than just measuring somebody's chair, there's a lot of... you need to understand how the body works, how the muscular skeletal system works so you can put it in practice. So as a nurse, yeah we can do the basic dressing, washing, measure somebody's chair, adjusting the height, but it's not that, there's a lot more input into it” (Charge nurse).

The distinct professional frames of reference were also evident by the respondents' thoughts on possible areas for role overlap. As in the case of elderly care the respondents recognised that they overlapped with regards to some of the tasks they performed with patients. The primary area of overlap with this client group centred on mobility and transfers, with the nurse, the occupational therapist and the physiotherapists indicating these were areas where they all had input. Although the respondents initially talked about how their roles overlapped it was clear within the data that they were referring to the overlap of tasks as opposed to roles. All the respondents acknowledged that although they may be helping patients to walk or

transfer, they contextualised these activities differently. The respondents drew on different frames of reference when engaging in the same task with patients. For example the physiotherapists saw transfer practice as a core element of what they did, whereas the occupational therapist although carrying out the same task viewed it as a means to progress onto something more functional, for example completing a washing and dressing assessment.

“we have different heads on when we’re doing it I suppose, I always have the head on of what will they need post discharge to be able to achieve what they have just shown me, whereas a physio would probably, I mean I don’t want to jump the gun, but probably would have stopped and think they can do that here and now that is enough from my perspective, tick yes, where as I suppose with an OT head on you, you think right they can do that but can they do that out of this setting, I suppose that’s where we differ slightly” (Band 6 OT).

The different professional frames of reference drawn on by the respondents were encapsulated in their knowledge and skills. This was evident in their objections to formalising the sharing of common tasks. Competence and perceived importance of the task were reported by all respondents as barriers to task overlap. The band seven occupational therapist interviewed felt that by addressing issues such as mobility or transfers, her time was taken away from doing other things with the patients, for example washing and dressing or meal preparation, something which she found extremely frustrating.

“I feel that we overlap with physios with the transfers and mobility and its like whose role is what, and is the patient benefiting from getting two lots of transfer practice in a day, whereas I feel that we could do more, more from the OT side and maybe go deeper into what their daily routines actually are, they might, they might want to do meal prep, those kinds of things, they tend to be more important to people, but just because of the logistics of the ward and the time frames that we work towards, within, we don’t, we don’t have those opportunities, so that’s where as an OT we don’t, I don’t feel that we fulfil our role just in elective orthopaedics” (Band 6 OT).

Defining the professional role - Professionally challenging and psychologically rewarding:

In addition to the specific knowledge and skills, what it meant to be a professional in this context was expressed in varying ways by the allied health professionals interviewed. Only the occupational therapy assistant (OTA) was able to give explicit examples of what, in her opinion, were the characteristics of professional work. This is not to say that the qualified professionals interviewed did not feel that they worked professionally, they expressed their approach to work in a more personal, and less abstract way than the OTA.

Describing her approach to practice as a professional, the OTA identified explicit values and attitudes, for example being smart, on time and polite as being attributes and behaviours associated with professional practice. For her, being professional meant being able to give a good impression of the service, but also of the Trust, and the NHS as a whole. The OTA recognised that her work was bounded by the requirements of the Trust but also by her knowledge and subsequent scope of practice, these latter points being seen as a positive aspect as it helped her to orientate herself and her work when dealing with patients.

“To be professional, to be able to erm do things in a professional way and be really thorough in the way that I work and really make sure that all the paper work and things, a systematic approach to things, and be and act in a professional manner as well and make sure that I have got enough knowledge and understanding of a subject so that when I am talking to a patient, for example like hip and knee education, I have made sure that I have got enough knowledge so I know, it’s at a good enough level so that I know what I’m talking about so when they are asking me questions at least I can give them you know an adequate answer and I don’t feel you know out of my depth, and try to be professional in my manner towards people as well, so you know you’re reflecting not just you and your team but the NHS as well and to take some pride in what you do and where you work”(Band 4 OTA).

In contrast to the OTA the qualified staff defined their work as professionals less through the abstract identification of attributes and behaviours, but more through

their relationships with patients. Communication skills were seen as essential. The development of a rapport with patients, making a connection and making a difference in terms of function or lifestyle, were all identified as being key elements of the role which also led to a positive experience for the respondents. The medical condition of the patients meant that the allied health professionals were able to engage them in rehabilitation. As a consequence of this they had time to work with patients and build a rapport. This was exemplified by the band five physiotherapist:

“Seeing the patients get better, that’s the number one you know, helping somebody get back to a normal functioning life which they might not have had before, erm, you get to know your patients quite well you especially the elder ones who are here for quite a long time you know because you are doing one on one sessions with them every day, so you build up a good rapport and have a bit of a laugh with them, it’s important to get them to smile I think as well, as they’re stuck in hospital” (Band 5 PT).

The development of a relationship with clients was seen by the band five physiotherapist as essential. Often patients would be reluctant to participate in therapy due to fear or pain, but by developing a relationship the therapists were able to remediate these fears and therefore engage the patients effectively in rehabilitation.

As well as engaging with patients at a personal level the respondents also indicated that they drew satisfaction from their work by addressing clinically complex problems. Working with patients with co-morbidities, or with complex social circumstances, challenged the respondents and made them question and develop their practice. However, in this context such opportunities were rare as the patients would only be admitted onto the ward if they were capable to engage in the process of care.

“in terms of fulfilment for your role yes, I prefer, I enjoy complex cases, but the easy cases make your day go quickly as well, and you get mini satisfaction, you get to tick boxes things like that with the less complicated patients, er, but I do, I much prefer to get involved in a complex case, something that is going to take days rather than an hour to solve whatever the problem is, liaise, you get to liaise with other professionals more with a complex case” (Band 6 OT).

The overall interpretation was that the lack of challenging patients resulted in the respondents placing more emphasis on their relationships with patients in order to give meaning to their work

Control over work:

The relationship between the process of patient care and the enactment of the respondents' professional frames of reference was brought to light through the frustrations and anxieties expressed about their work. What was clear from the data was that the process of care dominated what the professions were, or were not, able to do.

Lack of autonomy

Although the patients were generally medically stable the process of care to which the allied health professionals contributed was determined by the medical profession. It was acknowledged by the respondents that their work was bounded within the parameters set by the medical profession. For example, restrictions or recommendations made by the surgical team regarding a patient's rehabilitation, type of exercises, precautions or activities they could be involved in. Although they recognised this, the allied health professionals expressed frustration with being unable to fulfil what they considered to be key elements of their professional work. Focusing on a safe discharge or purely functional activities to enable a safe discharge was not reflective of either occupational therapy or physiotherapy. Pressure from the medical profession to discharge patients early led to the respondents to report a lack of autonomy or control over their work.

“it can be very difficult in times of, if they want patients home yesterday and they are not accepting the reasons why you are suggesting that you think they need more rehab, or I can't put the equipment in until tomorrow and they are not safe, that kind of thing just sometimes in the past when that has happened the attitude is, well that's not good enough, they are going home today, and its very difficult then to work and it becomes a very stressful environment to work in” (Band 6 OT).

The focus of the medical profession was summed up by the band five physiotherapist, where she felt that the priority of doctors was simply “keeping patients alive”.

In addition, the regimentation and predictability of the patients led a number of the respondents to question if their specific skills were needed. The occupational therapist in particular found working in elective orthopaedics specifically but in the hospital setting generally “demoralising” as, having studied for three years she was unable to practice what she considered to be her profession. This was echoed to some extent by the physiotherapists interviewed. The band five physiotherapist said that focusing on function all the time “went against the grain” as she was aware that she could offer so much more for the patients. In addition the band seven physiotherapist said that she always “felt as if she was apologising to the patient” as she was aware that she could do more, but due to the pressures for an early discharge and the increased workload she was unable to.

Organisation shaping role:

The respondents also felt quite strongly that they were unable to fulfil the more personal elements of being professional, due to the restrictions placed on them by the organisation. Pressures such as high patient case loads, a lack of time or resources, for example adequate staffing, coupled with a lack of structure to the working day (due for example to emergency cases in A and E) meant that the qualified staff did not always have the time to sit with patients and actualise their ideals of professional work. A number of the respondents made explicit how working in such a way made them feel “frustrated” (Band 6 OT) or “anxious” (Band 7 PT) having to compromise their work in such a way and as a result this led them to suggest that they had overall less job satisfaction.

There was a recognition that the role of the therapist was to meet the needs of the Trust over those of the patients. This is not to say that patients were denied care, but the need to meet targets with regards to rapid, timely and safe discharges certainly altered the focus and scope of the respondents therapy input. The band seven occupational therapist was quite resonant in her view that doing a good job meant an early discharge, as opposed to comprehensive occupational therapy.

“It’s funny it’s like what’s perceived as a good job, I know I think you would get recognition from doctors if you got a patient out early but that’s not necessarily a good job but it means that you’ve worked efficiently but whether that’s great for the patient “ (Band 6 OT).

There was a recurrent theme from all the respondents, that high patient case loads, a lack of staff and resources and, in the case of the physiotherapists, an often unstructured working day, led to them feeling that they were compromised in their ability to fully perform their perceived professional roles. A compromise in professional role was reflected by the band seven physiotherapist who, in comparing her current role to a previous one in the private sector, suggested that she had to change her view of what the role of the physiotherapist involved.

“one of the things that I noticed when I first came here I was thinking, I was looking at everybody working and thinking, you haven’t seen all the patients today, that was just unheard of, where I worked we had our list of patients we saw them, most times twice a day, you never went home having not seen a patient, you’d stay until you’d finished, but that happened so rarely that you had to stay late that it just wasn’t a problem, here, I mean there’s just no, and everybody just seemed quite relaxed about the fact that they hadn’t been able to see everybody, but I absolutely see why you would go mad, you know, I mean it did, I, I found it really difficult to start with that we were leaving people not seen, you know, and some days it would be more that one day because you know things would just get out of hand and we just couldn’t see everybody, then I realised well, you know if you get that worked up then you’re not going to last very long you have to just do what you can” (Band 7 PT).

Summary:

The roles and boundaries of the respondents in elective orthopaedics are determined almost exclusively by the processes of care prescribed by the medical profession. This has two consequences, the first is that in order to derive meaning

from their work the allied health professionals draw upon their relationships they have with patients, valuing these interactions. The second consequence of the apparent imposed structure upon the process of care is that roles and boundaries appear to be clearly defined and therefore not contested.

Chapter 6

Case studies three and four extended primary care and virtual wards

This chapter details the two cases studies from primary care. The chapter begins with details of how the cases were selected, and a summary of the data generation. As with the previous chapter, preceding the two case studies a description of the Trust from which the cases were drawn is provided. This includes the types of services offered by the Trust and a description of those services offered by allied health professionals. The format of the chapter mirrors mostly that of the previous chapter, however, due to the complexity of the services provided; common themes emerging from both cases are presented before the two case reports. This is followed by the two case reports, which provide the poly-narratives in the format of emergent themes.

Identifying the cases:

Once ethical approval had been granted, the time period between March 2012 and April of the same year was spent entering the research site, making myself known to the staff and identifying possible cases for study. Interviews were conducted with the professional leads for the most numerous allied health professions within the Trust (speech and language therapy, physiotherapy and occupational therapy), as well as with the allied health professional lead. These interviews provided background information regarding the type of services allied health professionals were involved in, and helped identify cases which could answer the research question.

In order to answer the research questions and furnish the needs of the extended case-based methodology selected, suitable case studies needed to provide opportunities where allied health professionals worked alongside one another with the same client group in the same setting. It was decided that cases should be drawn from the service which followed those patients discharged from either orthopaedics or elderly services in secondary care. Unlike secondary care, the services for orthopaedic and elderly patients were provided by a single newly formed service known as extended primary care and virtual ward. At the start of data

generation the extended primary care and virtual ward service was divided within the borough across four separate localities. Two of the four localities were managed by allied health professionals (a physiotherapist and a podiatrist respectively) and two were managed by nurses. Discussions with the allied health professional leads indicated that the roles and boundaries of the allied health professionals within the four localities differed according to the locality manager. Based on this, it was decided to select one case managed by a nurse (case report 3) and one managed by a podiatrist (case report 4).

Participant information letters were given to the locality managers responsible for the two cases identified. Through liaison with the locality managers a time was arranged for an outline of the proposed research to be presented to the teams, after which individuals were provided with written information and consent forms. Interested individuals were asked to contact the lead researcher so that interviews and observations could be discussed. The composition of the teams for the two cases meant that only occupational therapists and physiotherapists were involved in the research. Other allied health professions such as speech and language therapy, dietetics or podiatry provided profession specific services. As the data generation proceeded, members of the nursing staff involved in these services were also asked if they would be willing to participate in the study.

Data Generation:

Data was generated from the two cases from March 2012 to March 2013. A total of ten interviews and four hours of observational data was generated from the two cases. As well as interviews and observations, field notes were made whilst at the study site.

All interviews and observations were conducted in private offices. All interviews were recorded and transcribed verbatim. Observational data was gained during formal MDT meetings. The preliminary analysis of the interview data helped structure the recording of data during observations (the development of observational schedules). All interviews were sent to participants for member checking and correction. Only

seven interview transcripts were reviewed by participants and returned. In order to strengthen the validity of the analysis, case validation was conducted through presenting the work to staff employed at the research sites once full analysis and case study write up had been completed.

Figure 6.1 Team composition and data generation Case study 3 – locality managed by nurse

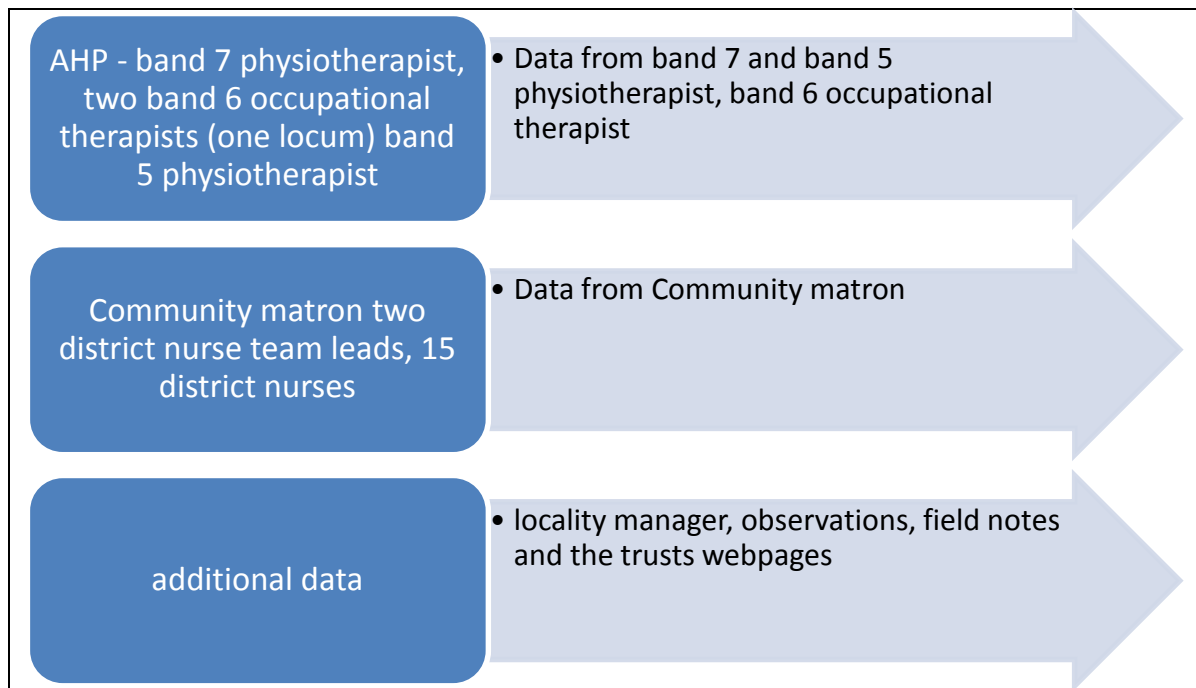
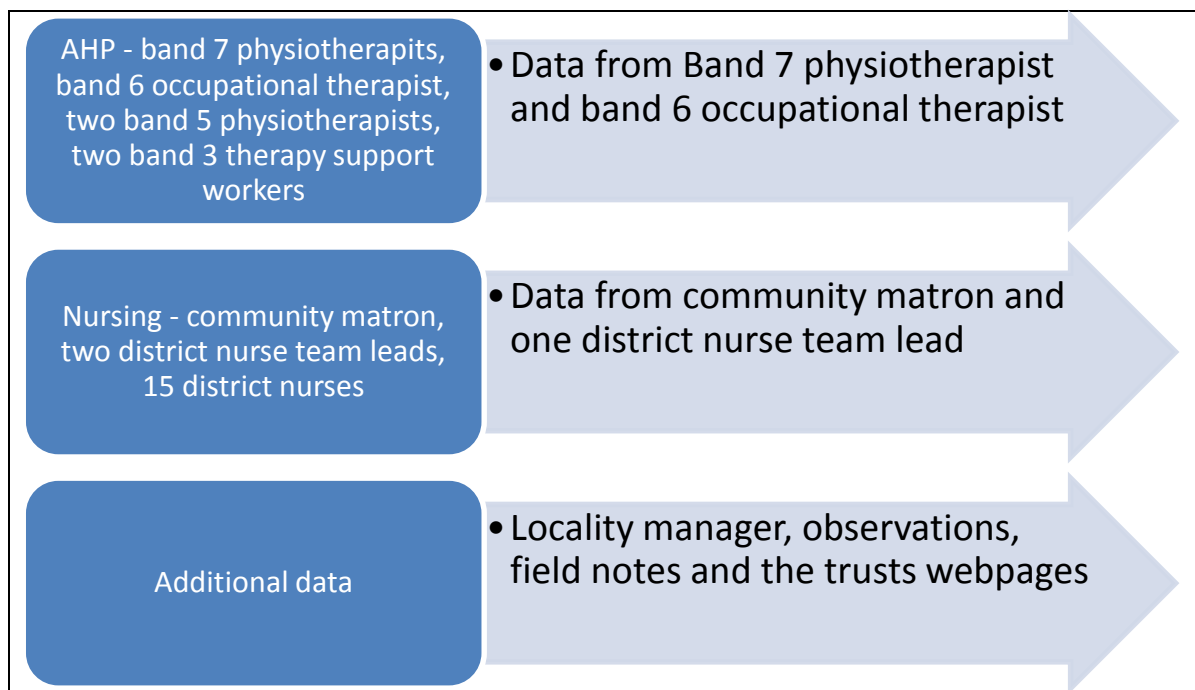


Figure 6.2 Team composition and data generation Case study 4 – locality managed by podiatrist



All allied health professionals and nurses at the two study sites were invited to be involved in the study.

For the locality managed by the nurse (case report 3) one occupational therapist (Band 6) two physiotherapists (Bands 5 and 7), the community matron and the locality manager agreed to be interviewed. Non-participant observational data was generated from two hours of observing MDT meetings which involved allied health professionals, nursing staff, and a GP. Field notes were also made whilst at the study site.

Table 6-1 Respondents details case study three – nurse managed locality

Respondent	Gender	Employment details	Number of years qualified
Locality manager	female	Non rotational	25
Band 7 PT	female	Non rotational	13
Band 5 PT	female	rotational	3
Band 6 OT	female	rotational	5
Community Matron	female	Non rotational	19

Five interviews were conducted for the locality managed by the podiatrist (case report 4). The locality manager, two nurses (the community matron and a district nurse), one physiotherapist (band 7) and one occupational therapist (band 6) were interviewed. Non-participant observational data was generated from three hours of observing MDT meetings which involved allied health professionals, nursing staff, social workers and discharge co-ordinators. In addition to this, field notes were also generated whilst at the study site. Written consent was gained from all staff for all interviews and observations of formal meetings.

Table 6-2 Respondents details case study four – podiatrist managed locality

Respondent	Gender	Employment details	Number of years qualified
Locality manager	Male	Non rotational	24
Band 7 PT	Male	Non rotational	8
Band 6 OT	Female	rotational	6
Community Matron	Female	Non rotational	20
District nurse	Female	Non rotational	16

Although stated in the methodology, documentation generated specifically relating to roles and boundaries by either case study were not examined. The reason for this departure from the initial method was that in both cases no specific documents generated by the allied health professionals outlining their practice were available. Information regarding the services offered at the study sites provide on the Trust's websites was examined, and in addition to the accounts provided by the respondents and the field notes made, served to contextualise the individual case studies.

Context of the two primary care case studies:

The study participants were asked to explain what they did in their day-to-day work and how they felt about working in this setting. All respondents across both cases reflected on the newly formed service in which they worked and the expectations of the managers with regards to how they should be working in the future. Augmented with observational data and field notes an initial starting point for the subsequent analysis was the identification of the processes involved in the day-to-day. Overall the first four stages of analysis outlined in the methodology and evidenced in appendix A, demonstrate the processes involved in constructing the contextualisation of the services as well as the two individual case reports. Although arising separately from the two case studies, through the analysis of the data it was apparent that, in their accounts of their work the respondents shared common concerns. The shared themes to arise from the two case studies are presented

before the case reports in order to contextualise the virtual ward and extended primary care service and highlight the complexity of primary care services overall.

Primary care services in the borough:

The cases selected provided services for the same London borough as those from secondary care. Details of the health care needs of the borough are provided in chapter 5.

Primary care services within the borough included GPs, pharmacists, opticians and dentists. In addition to this the borough also had a range of specialist services for the local population including children's, adult, older people and mental health services. The majority of the specialist services were provided by a large foundation Trust.

The foundation Trust from which the cases were selected provided both community and in-patient services for four inner city boroughs. The Trust specialised in mental health primary care, however, the services offered within the borough being studied were more diverse and included specific services for CVA, COPD¹⁶, Falls and diabetic patients. The Trust also provided a number of separate services for example foot health, speech and language therapy and musculoskeletal physiotherapy. Unlike the cases drawn from secondary care where all services were under one roof, the services in primary care were located across multiple sites across the borough (East London NHS Foundation Trust annual report 2010/11). In contrast to secondary care it was apparent that the services offered by the primary care Trust were somewhat fragmented. The relationships between services within the Trust and those offered by social services and third sector providers¹⁷ were incredibly complex and diverse. This complexity is highlighted in the case studies.

Political context:

¹⁶ CVA refers to cardio vascular accident; COPD refers to chronic obstructive pulmonary disease

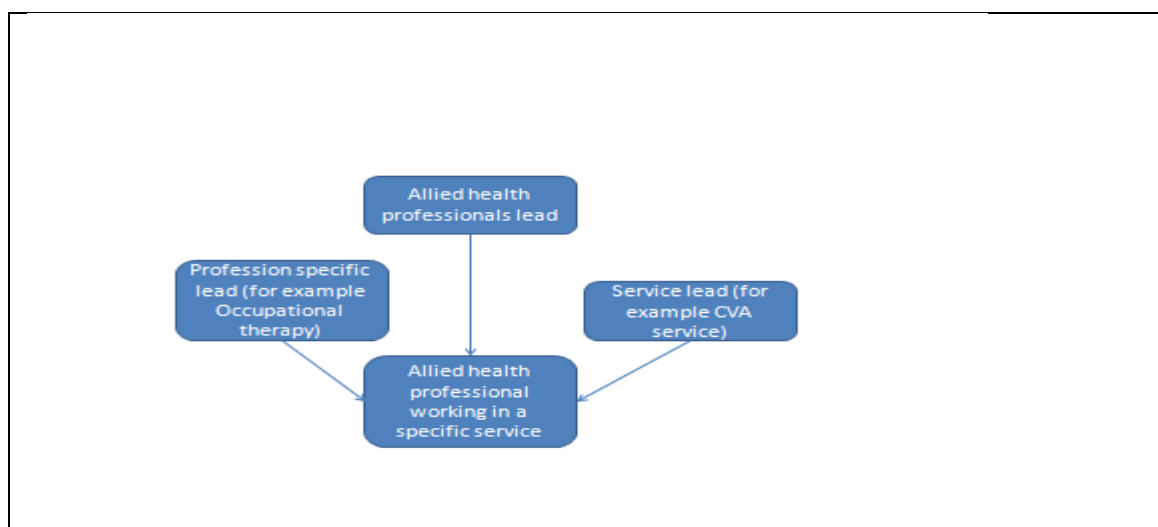
¹⁷ Charity and not for profit organisations

Prior to 2011 community health services within the borough were provided by the provider arm of the local primary care Trust. As part of the wider political reforms introduced by the Coalition Government, in 2011 the primary care Trust was abolished, the services and staff were transferred to a large foundation Trust. Although coming under the control of the foundation Trust the services within the borough maintained a sense of local identity through their status as an integrated directorate. Although the transfer occurred before data generation, there were a number of ongoing changes in service structure, management and delivery during the time of data generation.

Allied health professional input in primary care:

The management structure for the allied health professions provided a good example of the complex relationships between services. The allied health professionals within the borough were under the overall management of an allied health professional lead (a Speech and Language therapist). In addition to this each profession had their own professional lead, whose remit was to offer profession specific support and management. Because the allied health professionals worked in separate often diverse clinical teams they were managed, day-to-day, by the service manager for the respective service they worked in. For example the allied health professionals working in the CVA service were managed by the service lead, the professional lead and the allied health professional lead.

Figure 6.3 illustration of Allied health professional management structure within integrated primary care services



The Trust's services within this borough comprised both in-patient and community based services structured around specific client groups. As a result the allied health professionals were scattered across a number of services these being either uni-professional in the case of speech and language therapy or musculoskeletal physiotherapy or multi-professional in the case of condition specific services for example COPD¹⁸, Falls and CVA¹⁹ services. In addition to the client/condition specific services the Trust also provided a general rehabilitation service for any client aged 16 or over who did not fall within the remit of the condition specific services. Newly formed extended primary care and virtual ward service comprised multi-professional teams. The primary remit of this service was to provide rehabilitation in the community setting, support hospital discharges and where possible prevent hospital admission.

Extended primary care and virtual ward service:

As a service, extended primary care and virtual wards was relatively new. Prior to 2011 the types of services now under the remit of extended primary care and virtual wards had been provided by separate profession specific teams, for example district

¹⁸ Chronic obstructive pulmonary disease

¹⁹ Cardio vascular accident or stroke

nursing, occupational therapy and physiotherapy. In 2011 just after the primary care Trust became part of the larger foundation Trust, primary care services were reorganised. Rehabilitation services for the borough were divided into four localities and what had been profession specific services were brought together and integrated to form four separate multi-professional teams. The multi-professional teams included district nursing, Occupational therapy, physiotherapy, psychiatric nursing, one or more GPs and social workers. The service targeted patients who were at risk of hospital admission, or those who had recently been discharged from hospital and or those that required rehabilitation, as well as palliative care services. Therapy was provided in the patients' own homes.

As well as the restructuring of services into multi-professional teams split across four localities, the virtual ward model of service provision was included. The virtual ward is a model of service provision which aims to reduce hospital admissions through the management of acutely unwell patients in their own home. The underlying principle behind the virtual ward is the integration of care through the use of multi-disciplinary teams (Lewis, 2006).

Over the past 12 months the allied health professionals had gone from working as profession specific teams providing community based rehabilitation to being split into one of four localities making up the extended primary care and virtual ward service. Through the introduction of virtual wards their client group had also changed so that they were now required to provide services to acutely unwell patients as well as offering community based rehabilitation services.

To add to the complexity of the case studies and the service as a whole, and underlining the evolving nature of the service, at the start of data collection there were four locality teams with four managers. However during the life of the study (March 2012 to March 2013) the localities had been merged into two localities with only two managers, however the four teams remained.

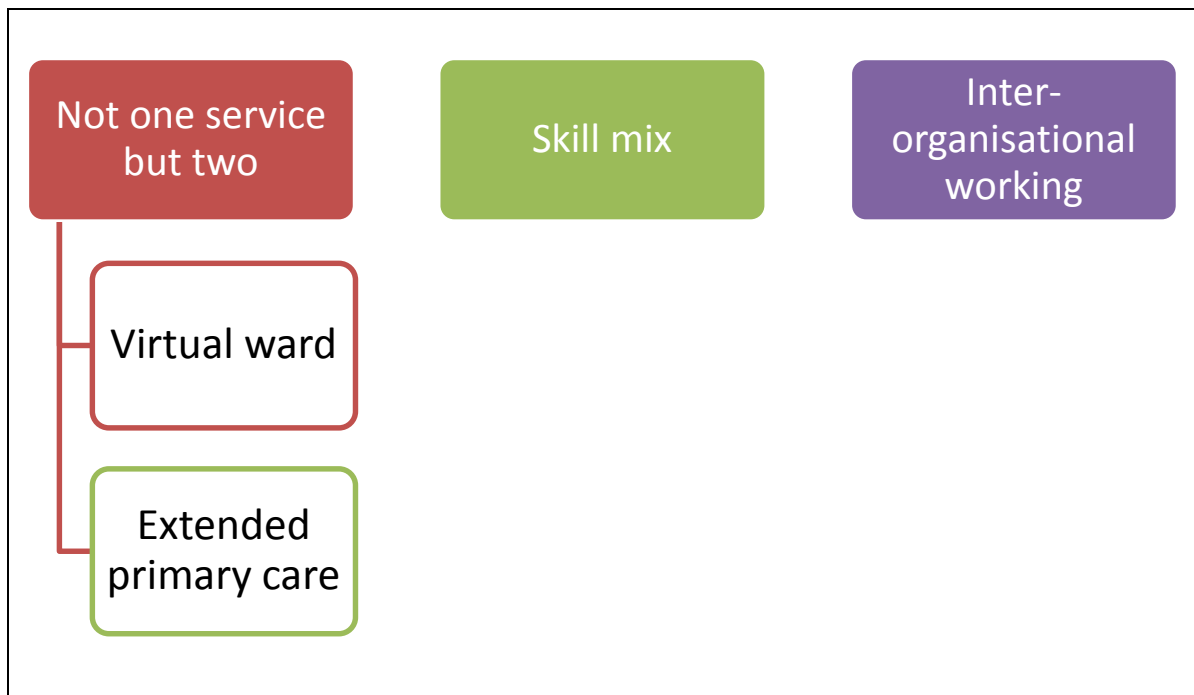
Although the four locality teams offered identical services they differed significantly with regards to their staffing levels. The numbers of district nurses remained almost constant across the four localities, however the number of allied health professionals and associated support workers differed greatly. This was exemplified by the staffing structures of the two cases studied.

The locality managed by the podiatrist employed three physiotherapists, one occupational therapist and two therapy support workers. In contrast the locality managed by the nurse employed only two physiotherapists and two occupational therapists, one of which was a locum. Explanations for the differences in numbers of allied health professionals across the four localities varied. Some respondents saw it as an inability to recruit to posts. For a period of about a year the locality managed by the nurse had only one allied health professional in post, a physiotherapist. The allied health professional locality manager suggested that the difference in staffing was due to how the funding was allocated by the different locality managers at the four different sites.

Common themes:

Departing somewhat from the linear case report presentation, common themes from both cases are presented here in order to underline the complexity of the newly formed service in which the respondents worked. Three common themes were identified. The theme, not one service but two, details how the respondents perceived the integration of the virtual ward and extended primary care provision. The interpretations of this newly introduced service are captured within the two case reports in the form of the subtle power relationships expressed by the respondents between the professions, and their perceived effect on patient care overall. The second shared theme reflects the expectations of managers for staff to work differently through the blurring of traditional professional roles. The theme, skill mix, introduces this concept which is developed within the two cases individually. The final common theme, inter-organisational working, captures the respondents' concerns regarding how their work fitted into services being offered by other providers specifically the local authority.

Figure 6.4 common themes and categories within extended primary care



Not one service but two?

In their descriptions of their work, all the respondents, apart from the locality managers, made a clear separation between extended primary care and the virtual ward.

One of the aims of the extended primary care and virtual ward service was to offer a seamless service for patients who, after a period of acute illness, which may or may not have resulted in hospital admission, required therapy input which addressed their acute, and if needed, rehabilitation needs. This integration of acute and rehabilitation services were described by the nurse locality manager a “corporate case load”, where patients stayed with the team until all aspects of their therapy had been addressed. Unlike the manager all the therapy and nursing staff interviewed at both study sites described the service as being clearly split.

“We’re kind of split into two services here, as far as physio is concerned, we pick up the virtual ward patients who are your early supported discharges and your admission preventions, and we also pick up community based patients,

so we see the patients who would traditionally gone to a community service” (Band 7 PT case study three).

“so in the extended primary care team and the virtual ward teams and the, I mainly work with virtual ward patients and the palliative care patients now ‘cause we have another OT with us in the team, before I was doing it all ‘cause we were just short staffed” (Band 6 OT case study three).

“Well the difference for the ones who are being looked after by the district nurses they have chronic conditions, for example leg ulcers, they can’t come to the virtual ward because on the virtual ward we are meant to have patients for 14 daysunless they have multiple needs then they can come” (Community Matron case study four).

“I have two case loads, one being the virtual ward and one being extended primary care” (Band 6 OT case study four).

There was extended primary care, which the staff saw as “traditional” community physiotherapy, or district nursing for example, and there was the virtual ward service, which was new and required them to work differently.

Virtual wards:

The aim of the virtual wards was to support patients with acute episodes or exacerbations of ongoing illness recover in their own homes. The types of patients seen were acute UTIs²⁰, exacerbations of COPD²¹, or Falls patients, and the remit of the virtual wards was to either prevent the need for hospital admission, or support patients who may not have recovered fully but had been discharged from hospital.

A condition of being admitted on to the virtual ward was that patients needed the input of more than one member of the MDT (if this was not the case then they were seen in extended primary care, underlining the difference between the two services). The teams had virtual ward rounds mirroring those of the secondary care setting, during which all patients on the ward were discussed. As all patients on the virtual ward were seen by the MDT, they were, by default, on the case load of the allied

²⁰ Urinary tract infection

²¹ Chronic obstructive pulmonary disease

health professionals, regardless of whether they were actively treating the patient or not.

The acute needs of the patients and the complexity of managing these needs in the home environment resulted in the nurses and the allied health professionals focusing on areas which mirrored those seen in the secondary care setting. For the nurses this meant ensuring that patients were hydrated and nourished, monitoring medications, dressings, and catheters for example. The physiotherapists' role in this context was to treat the patients' respiratory problems if required or begin remedial exercises to facilitate mobility in their home environment. Due to the often poor medical condition of patients, the work of the physiotherapists was restricted to ensuring that patients were safe in their home environment. This focus on safety was also reflected in the work of the occupational therapists. Both occupational therapists interviewed felt that their role in the virtual wards was restricted to focusing primarily on manual handling issues.

"It's more the manual handling, so if there's been difficulties with the transfers and they still aren't getting out of bed or they're doing unsafe techniques or if there's carers having difficulty with say managing their bed mobility, we're providing equipment for that. So it's a lot around the manual handling and equipment provision" (Band6 OT case study four).

"Clients who are referred to the virtual ward are normally those who are medically unwell...therefore an emergency package of care have to go in, the physio has to go in and look at mobility and I'll go in to look at the environment, if they're safe" (Band 6 OT case study three).

The patients on virtual ward were unwell and therefore unable to engage in rehabilitation, the role of the occupational therapist focused on keeping the patient and the carers including the staff (i.e. district nurses) safe. This was done through the issuing of equipment for example hoists or bath boards.

Extended primary care:

All respondents reported that their role in extended primary care was to promote patients' independence.

The need to facilitate patients to be less or independent of health care input was echoed by the nurses, the physiotherapists and the occupational therapists.

In contrast to the virtual wards, the allied health professionals and the nurses carried their own individual case loads and focused (on the whole) upon their profession specific remits with regards to the services they provided. Patients were referred from primary or secondary care services directly to the individual professions. The different professions saw the patients independently of one another even though the patient may have been receiving input from more than one profession. The respondents described their work in this context as being reflective of “traditional” community based nursing or physiotherapy, and placed emphasis on the autonomy they had in their practice.

“A patient could be on a matron’s case load, a DN’s caseload and my case load but us three going in separately doing three separate things, so the DN’s might be just going and administering insulin, whereas matrons every 15 days just follow up with medication while I go in and do rehab. So those are independent of one another” (Band 7 PT case study four).

Detailing their roles in extended primary care the therapy staff emphasised the importance of rehabilitation. The occupational therapists described their role in extended primary care as focused on patient centred goals primarily around activities of daily living and domestic activities. Working with patients with long term conditions, for example, RA²² or Parkinson’s disease, the occupational therapists’ role was to help individuals maintain or regain their independence. The physiotherapists described their role in extended primary care as providing rehabilitation to patients in their own home. The types of conditions seen were orthopaedic, for example following joint replacement surgery, falls, respiratory conditions and neurological conditions. The focus here was on rehabilitation, described as working toward patient centred goals, the aim of which was to maximise function and independence in the community environment. This ranged from helping someone be able to go to the shops to helping someone to be transferred without the use of equipment.

²² Rheumatoid arthritis

What was clear from both cases was that although being viewed by the managers as a single service, the structure, types of patients and level of autonomy expressed by the respondents in extended primary care differed greatly from that of the virtual ward setting. This led the respondents to view the two as separate services.

Skill mix:

As well as aiming for a “corporate case load”, there was clear evidence from the locality managers that a primary aim of extended primary care and virtual ward service was to engender new ways of working through the introduction of skill mix. Described by the AHP locality manager as “focusing on those functions within everybody’s roles which don’t take a great deal of skill”. Skill mix was directed toward those areas where no specific professional training was required or where detailed knowledge was not needed. The introduction of this sharing of skills was seen by the managers from both cases as a positive, in that it would “improve the scope of the individual and increase their interest in their work” (locality manager case study 4). In both cases the respondents were aware of the introduction of skill mix, however, within and across the cases the acceptance and incorporation of the concept varied considerably. As an example, a slightly more cynical view of skill sharing was expressed by the physiotherapist from case study four who saw the introduction of skills sharing as a means of saving money. The emphasis placed on skill mix by the managers from both cases provided a unique opportunity to answer my research question in this context.

Inter- organisational working.

Enablement, a service offered by the local authority provided services to patients for up to six weeks (after six weeks patients had to pay for ongoing services) to help support them in their own home, once they had been discharged from hospital. Enablement offered services to patients to help them with activities of daily living, for example self-care, meal preparation, transfers and mobility. From the data it appeared that all patients discharged from hospital that required ongoing support or rehabilitation were automatically referred to the enablement team.

The enablement service employed enablers, whose role it was to provide rehabilitation to patients in order to help them be more independent at home. Enablers were not trained allied health professionals. The service did not have physiotherapy input, however, it did have social services occupational therapists. If after 6-8 weeks the patients felt that more rehabilitation was needed then they could refer themselves or via their GP to the extended primary care team.

The band 7 physiotherapist from case four reported that, since the introduction of enablement there had been a decline in referrals to his service in extended primary care. Patients, who would have normally been referred to physiotherapy or occupational therapy, for example patients with total hip or knee replacements, were now going to enablement. This caused concern from the therapy staff as they felt that patients were not getting the correct level of input in order to fully address their rehabilitation needs.

“I think one of the other reasons why there is also a drop is, I’m not trying to be vindictive so please do excuse me, is partly to do with social services and I’m going to be very honest and blunt about my opinion. We have an enablement team within the community and when there is a patient discharged, social services, on the form, have enablement as a checkbox, so the patient automatically goes to enablement team. So now the patient goes to enablement team – it’s cheaper as opposed to going to a skilled professional” (Band 7 PT case study four).

The concerns regarding enablement were expressed in a number of ways by the respondents. The occupational therapist from case study three reported that, although enablement had occupational therapists they tended to refer patients to her extended primary care service for rehabilitation as opposed to providing it themselves. The physiotherapist from case study four raised issues of safety, suggesting that due to the lack of qualified staff patients may be being put at risk. In addition he said that patients had to access his service through their GP as opposed to receiving referrals directly from the hospital. The concern regarding safety was echoed by the locality manager from case study three, suggesting that enablement had a focus on care as opposed to health and cited an example of where this had placed a vulnerable patient at risk.

“I have struggled and I’m not alone at trying to understand what the enablement team is achieving because they kind of withdrew a lot of packages of care when patients were in the acute setting and then needed a package of care to be discharged. Instead of getting that package of care my understanding is they go through enablement but I have had a bad experience already through visiting a patient in primary care whereby the patient had severe dementia, had been in the acute setting last summer, was discharged and referred to the enablement team. They couldn’t enable him so they discharged him to nobody” (locality manager case study three).

The relationship between the extended primary care and virtual ward service and enablement was fragmented, with staff based in the extended primary care and virtual ward service not fully understanding the remit of enablement. The occupational therapist from case study three said that although she was aware that social services occupational therapy staff were involved in enablement, she was unsure if their involvement extended to rehabilitation. She continued by suggesting that things got “a bit tricky” if a patient was under both her service and enablement as it was not clear who was or should be doing what.

“enablers normally just look at personal care, they don’t do an awful lot of transfer practice. I deal with mobility, shopping, cooking, they don’t do any of that, the majority of stuff is personal care and there are OTs within the enablement team, however a lot of the staff refer to us for rehab and it is to be, what’s the word I’m looking for?....We are all to meet and distinguish and establish rules and boundaries and the meeting has been cancelled five times, so not by our side, by the enablement side and the managers” (Band 6 OT case study three).

The breakdown of interagency working acknowledged by the respondents brought into question the recent and ongoing reforms concerning community based services and the difficulties and challenges this presented allied health professionals working in this context.

“we’re all a big jigsaw puzzle at the end of the day, we’ve all got to meet the demand whether it’s acute, primary, GPs, we’re all cogs really and we all fit

together and the patient we're supposed to fit together" (locality manager case study three).

Summary:

Arising out of the analysis of the individual case studies, these common themes represent the shared issues reflected in the data and serve to underline the contextual complexity of the services provided in primary care. These common themes are elaborated on within the individual case reports, which highlight the individual difference between the two cases. The following sections details the two case reports in full.

Case study three Nurse managed locality

Study site:

The extended primary care and virtual ward team were based in the modern multi-purpose health centre to the east of the borough. Opened in 2004, the centre was a three storey building housing a number of services. On the ground floor were GP clinics, phlebotomy services and a pharmacy which could be accessed by patients seven days a week. The first floor housed offices and multi-purpose treatment rooms. The second floor was just offices and it was here that the team was based. The extended primary care and virtual ward team shared an open plan office. The second floor only covered half of the building's lower dimensions and although open plan, the shared office was small. As well as an office there was a small kitchen area, toilets and a large meeting/staff room. Because the team were community based they were rarely all in the office at the same time and the meeting/staff room was hardly ever used. All interviews were conducted in the staff room. Due to the small office space the team used a system of hot desking when they were in the office.

Emergent themes poly-narrative:

Two themes emerged from the data. The first theme, illuminates how the respondents sought to define their roles and boundaries in an evolving service. A number of interrelated categories form this theme, which demonstrate the complex interactions contributing to roles and boundaries and the often covert power relationships associated with these. Of significance for this case study was that the allied health professionals felt that by having a nurse as their line manager the nursing profession was being privileged over that of the therapy professions. This perceived domination by nursing was reflected in the allied health professionals' reactions to the changes introduced through the incorporation of skill mix and the need for MDT working in the virtual ward environment. The service had been structured in a way which placed nurses, and in particular the community matrons, in a position of power

with regards to determining what the allied health professionals did within the virtual ward setting.

The second theme centres on the allied health professional's perceived lack of scope for rehabilitation since the introduction of the virtual ward as part of the service. All allied health professionals based in this locality felt that rehabilitation for patients with long term conditions had been affected as a result of the changes introduced in primary care.

Figure 6.5 Emergent themes case study three – nurse managed locality



Defining roles and boundaries in an evolving service:

In the context of the new and evolving extended primary care and virtual ward service, the respondents drew on a number of resources in order to define their roles and give meaning to their day-to-day work. The respondents drew on their professions and in some cases other professions' frames of reference in order to define their roles in this context. In addition the respondents also positioned their service and their work by contrasting it to hospital based services.

Professional frames of reference:

It was acknowledged by all the respondents that the different professions viewed patients' problems in a different way.

“obviously OTs and physios kind of have two different hats on when they're looking at transfers, and then we do joints even if it's not equipment based, just looking at transfers as two people cause when an OT comes to look at it we'll be looking at more the function of how to get say on and off a toilet, on and off a commode and actually giving a functional basis” (Band 6 OT).

These different hats were a reflection of the different professional frames of reference drawn on by the respondents in order to give meaning to their work. Different frames of reference were also evident in the respondents' descriptions of team work. The occupational therapist for example in comparing working in this team to previous experiences of working with only allied health professionals, described her difficulties and frustrations of having to explain and justify her actions.

“ I just found it really hard when I first came here. I think I'd done community before, both community and neuro community, but I've always worked on a therapies team, so everything's always been you work as an MDT, but you work on a team of five or six therapists and you're all like-minded and you can discuss your caseloads and everything. And then you come here and it's very nurse-heavy and there isn't that understanding between the two professions, the way you'd expect it, and I find communication's really challenging at times” (Band 6 OT).

This feeling of distance between the therapy staff and the nurses was reinforced by the band five physiotherapist who said that she felt there was a “professional divide” between therapies and nursing.

The differences in professional frames of reference highlighted between therapies, but more so between therapies and nursing, meant that the band seven physiotherapist had to define and explain her role and justify her decision making.

“I have to explain my clinical reasoning a lot, so whereas before I could just say, ‘this is the patient, this is what I’m doing, and everyone would understand why I was doing it and what we were going for, I am explaining, ‘I’m doing this because of this, and this is an issue because of this....working with therapists, everybody understands how to get from (a) to (b) without taking them through it” (Band 7 PT).

At first sight the differences in professional frames of reference appeared as a barrier between the professions, however, as detailed in the next category the flexibility and permeability of an individual’s professional frame of reference varied.

Skill mix a catalyst to change and resistance:

The emphasis placed on skill mix had brought into question the allied health professionals’ roles and boundaries and for some had widened the division between nursing and therapies. It was clear that the nurse locality manager was placing emphasis on the need for the allied health professionals to incorporate nursing skills into their practice, as she said “people are very precious and the whole service redesign will address that” (locality manager case study three).

The reaction of the allied health professionals to the introduction of nursing skills into their work, and the perceived dominance of nursing, provided insight into how they defined their roles and boundaries, but also how through the adoption of nursing roles acceptance and legitimacy could be gained.

Although the allied health professionals recognised the logic behind skill mix, their acceptance of it varied. All the allied health professionals were concerned that

through the introduction of skill mix they were being expected to take on the roles of the nurses. The band seven physiotherapist commented that she was:

“worried that at the end of the day, if we’re not careful, we might probably end up doing a nursing job rather the physio one that we’re employed to do”

The band five physiotherapist and the occupational therapist clearly resented the introduction of skill mix in the form of the adoption of nursing roles. The opposition contributed to the apparent divisions between therapies and nursing.

“We’ve now been told that whenever we go in to assess a patient we have to do like Waterlow score, which you’d ask anyway, but they’ve gotten to the point where they want us to check pressure areas.....the OT and I came on board and we’re both like well no that’s not acceptable, we can help you and we can try and make sure patients who need you are being seen by you but at the end of the day, it’s not our job to be cleaning sacral sores” (Band 5 PT).

Their concerns were framed within their professional frames of reference. Issues of competence, knowledge and accountability, as well as what was seen as “acceptable” from the patient’s point of view, were raised in order to support their view that the adoption of nursing skills into their work was not appropriate.

“I try and resist it, so there has been talk about taking blood pressure and there’s been talk about us checking sacral sores. I don’t feel that should be something, particularly with the training..I’m like ‘Well if you really feel that that’s something I need to do then provide the right training.’ But I feel that OT, we try to keep on top of our wait list and actually its fine now that we have got another member of staff, but we’re doing OT things and if you try and make us do nursing things or HAD things it’s going to take away from the time we have doing OT things and we already spend a long time with our patients” (Band 6 OT).

Their resistance was augmented by placing their views within the wider financial and political context.

“The problem is where does the CSP stand, where does the HPC stand, in the sense that if I went in and assessed it and the patient cited foul play” (Band 5 PT).

Although services had been re-organised to accommodate the new virtual ward there had been no increase in staffing. As a result the band five physiotherapist and the occupational therapist felt that skill mix was a means of getting staff to do more for less and thus a mechanism for saving money.

The grounding of practice and resistance to skill mix though the utilisation of professional frames of reference was also apparent in the emphasis placed on the need for profession specific supervision by the band five physiotherapist and the occupational therapist. They both felt that profession specific supervision was vital for their own professional development. The separation of professional supervision and line management meant they had to look beyond their immediate team in order to find support. However, due to staff shortages and a lack of permanent occupational therapists within the Trust in this borough, this proved difficult for the occupational therapist and left her feeling isolated and unsupported in her role. This was compounded by the fact that she was, until very recently, the only occupational therapist in this locality.

In contrast to the band five physiotherapist and the occupational therapist, the band seven physiotherapist had a very different view. She saw the adoption of nursing skills as an extension of her practice, an additional layer to her professional frame of reference. Through engaging in CPD²³ with the nurses, the band seven physiotherapist actively sought opportunities to extend her practice. She valued the ability to do, in her view, a comprehensive assessment and identify issues, which, although not traditionally within the scope of physiotherapy practice, may influence her work as a physiotherapist. She provided examples of where she had taken a patient's blood sugar levels, or assessed their vision before engaging the patient in exercise in order to illustrate how her work had changed. She was clearly aware of how her new skills had enhanced her physiotherapy practice:

²³ Continued professional development

“When I see the patient, depending on the referral, they come out quite, more compared to the other bits because while I’m just touching on the other bits, I just more of the baseline skills, you know sometimes baseline information also, which tends to help me make an informed decision on how to manage the patient. Because there are some things like blood sugar or little bits that you have....helps when you are carrying out your Physiotherapy assessment, so it comes in hand in hand, compared to before where I would go in and concentrate on just the physio bit” (Band 7 PT).

The band seven physiotherapist appeared to be able to blend the new skills and knowledge into her existing professional frames of reference. This was enhanced by acknowledging that through the adoption of nursing skills she was better equipped to deal with the types of patients she was now seeing in the virtual ward context.

There was an impression, when comparing the contrasting reactions to skill mix expressed by the two physiotherapists, that the adoption and development of new skills into practice, was influenced by the experience of the individuals concerned. This interpretation was supported to a degree by the occupational therapists, who felt that although she was a band six, she was still developing her skills as an occupational therapist.

“you’re taught a certain amount but OT is so broad we have a three-year degree, we can’t learn everything in three years otherwise there would be no banding. And you’re taught so much and each university has different emphasis and you’re still learning the actual clinical stuff when you’re band5/band6.....- I’m still learning the clinical stuff” (Band 6 OT).

Adopting nursing skills to fit in:

In analysing the responses from the allied health professionals, it was apparent that through the adoption of new skills or not, individuals positioned themselves within the team.

Through the incorporation of nursing skills into her work the band seven physiotherapist felt that she had been accepted by the majority nursing team. Through the use of language which was recognisable to the nurses, the band seven physiotherapist felt she had gained acceptance and legitimacy within the team.

“Working with the community matron, I think, no, I know not I think now, I’ve come to a place where they respect my clinical judgement for some of the patients, and I think it’s also because now I speak the language” (Band 7 PT).

This was enhanced, in her opinion, by gaining positive feedback from the GPs. This not only increased her confidence but also sent a message to the nursing staff that she was competent to be taking on the new roles. The community matron acknowledged that the band seven physiotherapist had changed her practice. Through taking on nursing roles, using their language and accessing their frame of reference she had in the words of the matron “blended well” into the team.

Underlining the perceived dominance of nursing in this case, the community matron interviewed, said that skill mix had not been discussed with her or the rest of the nurses and therefore felt that it did not apply to the nurses. The perception of skill mix as focusing on acute, nursing skills as expressed by the allied health professionals was therefore reinforced.

Nursing staff as gate keepers:

The perceived dominance of the nursing staff, and in particular the community matrons was underlined by the band seven physiotherapist. At the start of the new extended primary care and virtual ward service being operational, it was the community matron who was responsible for assessing and admitting patients on to the virtual ward. The band seven physiotherapist and the occupational therapist were frustrated by the lack of control over which patients they should see. At the time of the study the band seven physiotherapist, possibly due to her acceptance by the nursing staff was now able to assess and admit patients. Through the actions of the physiotherapist the system had been changed. However, the band seven physiotherapist did say that this change had not been replicated in the other localities.

The occupational therapist still relied on the matron or now, the band seven physiotherapist, to determine if she should be involved with a patient. In order to access patients on the virtual ward, the occupational therapist needed a direct

referral from either the community matron or the band seven physiotherapist. However, the occupational therapist commented that during the daily ward rounds she would actively listen out for anything that may sound as if it required occupational therapy.

“so if when they’re talking about them (patients) and there seems to be something that comes up that sounds occupational therapy related and they haven’t picked up needs the OT, then I could say, ‘Oh do you think they need OT?’so it’s also me listening to try and find if there’s any OT needs” (Band 6 OT).

Clearly on the periphery, the occupational therapist was reliant on the other professions to access patients, possibly contributing to her sense of isolation and frustration.

The allied health professionals described ways in which they were able to access patients who were not admitted on to the virtual ward. During the ward rounds, if a new referral was discussed and it was decided that the patient did not need admission to the virtual ward, but the occupational therapist or physiotherapist (prior to her new status) felt that the patient would benefit from therapy then they referred them onto their extended primary care case load.

We are not Secondary care:

Another way for the respondents to define their roles and boundaries was through comparing their work with therapists or nurses based in a hospital setting. Through outlining their day-to-day the respondents contrasted their work with secondary care or more specifically hospital based work as a means of detailing and defining what they did but also, more importantly, what they did not do.

The locality manager made the distinction between primary and secondary care, or more specifically a hospital based service, very clear. In her view hospitals were all about conformity.

“Having worked in the hospital I think it’s easier to make patients conform to a building and its regime and probably that’s why I like community so much

because every day is a challenge. Your patients are in their own home, you're the guest, you're not in charge" (locality manager case study three).

In hospitals patients' choices are limited, their life is regimented, and they have less freedom or independence to do things for themselves. But once discharged to the community patients are expected to cope. In contrast, the locality manager described community based services as, at its heart, aiming to facilitate greater patient independence. In the community more emphasis is placed on getting family members involved, patient choice is seen as paramount, this being reflected in the importance placed on joint decision making.

The negative view of hospitals was reiterated by the community matron and the occupational therapist, with the latter suggesting that hospitals were not patient focused. The occupational therapist, reflecting on her own work in the secondary care context, said that pressures for discharge meant that there was no time for rehabilitation, no time to develop a relationship with patients, an aspect of her work she valued highly in the community setting.

"some people (therapists) really don't like the hospital because it's too quick and it's too intense and too much quick pace and I don't feel that you maybe get to know the patients in as much a therapeutic way in the hospitals" (Band 6 OT).

Through the process of differentiating their work from their experiences and perceptions of secondary care the respondents were able to define the ethos of their service and the focus of their roles. In doing so, the respondents were highlighting the importance context plays on shaping roles and boundaries.

The importance of context was underlined by the respondents' thoughts regarding the concept of skill mix. Both the band seven physiotherapist and the locality manager felt that within the hospital setting, traditional hierarchies and the division of labour meant that skill mix in this context was not needed and if introduced would not work.

Through their reflections on secondary care the respondents reinforced a number of the themes which emerged from cases one and two. The band five physiotherapist felt that rehabilitation did not happen in the hospital.

“patients then going up and down the stairs for three years, had a stint in hospital, can’t do the stairs anymore, ‘well just put in a stair lift, and we’ll discharge the patient’, Or we had one a couple of weeks ago who went into hospital, wasn’t rehabbed back to her baseline in hospital, barely rehabbed at all, because she wasn’t feeling well and she was abused constantly in hospital, but was mobilising from bed to toilet before she went in” (Band 5 PT).

This lack of rehabilitation made the band 5 physiotherapist’s work in the community a lot harder. A lack of rehabilitation in hospital, and poorly planned discharges, meant that patients were being discharged with greater social and care needs. She felt that the hospital team used her service as a safety net. Knowing that rehabilitation could be continued in the community, and care packages could be put in place, through for example enablement, meant that the hospital could justify discharging patients who were not fully able to cope.

Rehabilitation missing out:

The reconfiguration of the services, with the introduction of the virtual ward was having an effect on the way allied health professionals worked and the type of services they were able to offer patients.

The introduction of the virtual ward without any additional staffing to cover this service meant that patients needing rehabilitation in extended primary care were seen as a lower priority. The patients in the virtual wards were often unwell and therefore required immediate input. In order to be able to cope with the increase in patients and the move towards acute, as opposed to ongoing, therapy, the allied health professionals were discharging patients from extended primary care sooner than they would have liked.

“virtual ward patients tend to be as far as therapy are concerned, tend to not need too much because it’s more of a...as far as function and rehab go, tend to be more chest patient anyway so you’re going in and just clearing chests, that sort of stuff, so you’d keep them on and you’d monitor that until they’re back to baseline anyway. I find it’s the more functional rehab patients that

are..you know somebody who should have rehab potential maybe isn't given the time they need to achieve that potential because we don't have the manpower to give it to them....if we had more staff there would be more time to allow for rehab, but the emphasis is more on discharging that it is on rehabbing" (Band 5 PT).

Although the need for managing patients with long term conditions was widely recognised, the introduction of more unwell patients into the community meant that roles and priorities moved away from patients with ongoing needs. This is reflected by the band seven physiotherapist, who through the adoption of nursing skills was better equipped to deal with more acutely unwell patients on the virtual ward. In addition, it was clear that as the service had evolved over the past year, and staffing levels had been adjusted in order to reflect this, rehabilitation was not perceived to be the priority.

"When we came down here we were like a full team, we had a band 7 OT, band five OT, we had one physio which was me, we had the rehabs, we had two support workers and we had a physio tech, but in the space of a year, we lost the band 7, we lost the band 5, we lost the physio tech, I lost the rehab support workers, and by the end of the year, November, I had the other rehab support worker going in on a long term sickness" (Band 7 PT).

Although things had improved it was clear from the therapists that their roles now were directed toward treating unwell patients, the lack of rehab support workers within the locality reflecting this.

The community matron also reported a change in role. Before the introduction of the virtual ward the matron had a patient case load which focused on managing long term conditions in the community. Since the introduction of the virtual ward to the service, however, her role had changed to only focusing on the acute patients.

"we used to provide some sort of preventative work or some of those we think could fall in and out of virtual ward. So we had to discharge everybody on our caseload. Either we put it into district nursing or GPs, or if they call we still take the call if we know the person is quite...one of those with a long-term

conditions, and to avoid a hospital admission, so we then could focus just on virtual ward” (Community matron).

Although a clear rationale for rehabilitation in the community setting was expressed by the respondents it is difficult to see how this could be fully actualised. Placed in the wider context of how the extended primary care and virtual ward service was operating, cuts to services and the role of other agencies, for example enablement, the feeling expressed by the allied health professionals that rehabilitation in this context was missing out was clearly justified.

Summary:

It is clear from the analysis that as a result of the introduction of the virtual ward the roles and boundaries of the allied health professionals have been brought into question. As a result the respondents drew on a number of resources in order to give meaning to their work. Of importance are the differences between the occupational therapists and the band five physiotherapist compared with the band seven physiotherapist. The latter seemingly able to move beyond her profession specific frame of reference and as a result embrace new skills and adapt to new roles. Finally, of importance is the concern expressed by all the allied health professionals regarding the lack of scope for rehabilitation in their work since the introduction of the virtual ward. The move away from focusing on the long term needs of clients with long term conditions brought into question the allied health professionals’ purpose in this context.

Case study four Podiatrist managed locality:

Study site:

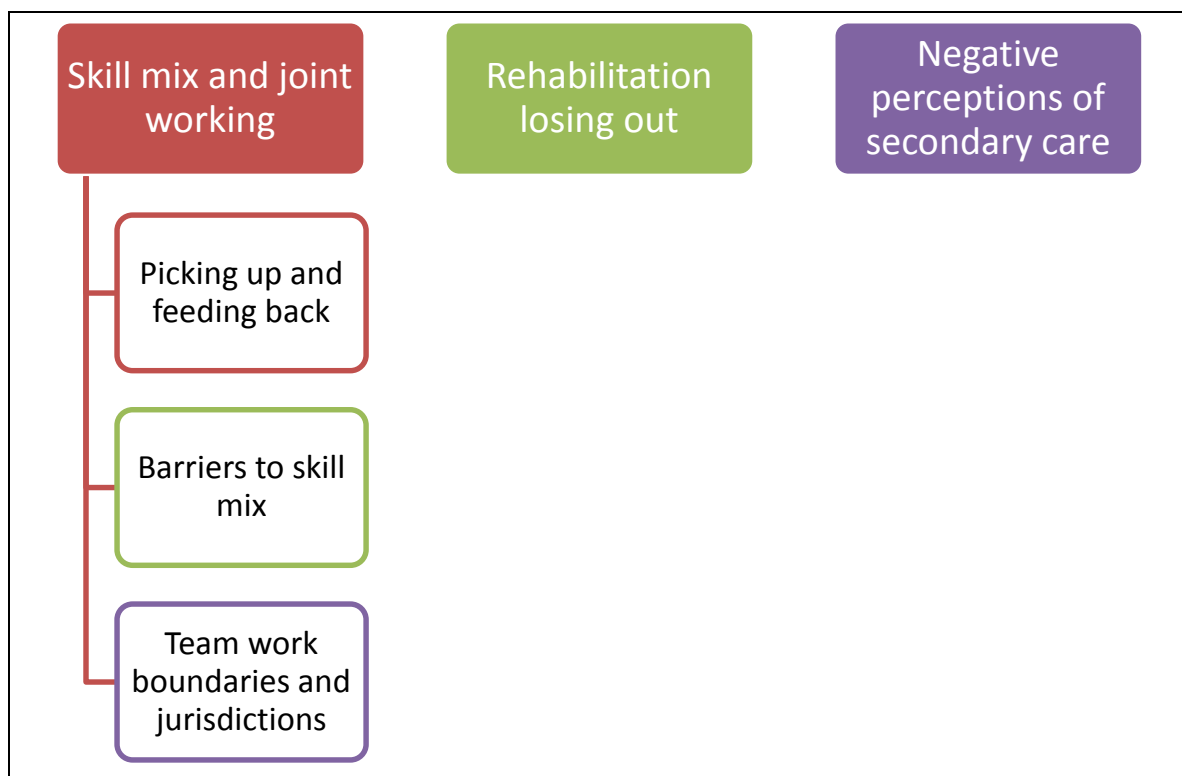
The team were based at a large clinical facility in the centre of the borough. They occupied a large open plan office on the top floor of a two storey building which was part of a complex forming a primary care hub for the Trust in this borough. The building housed a number of services including inpatient and day hospital elderly services, and diagnostic facilities.

The top floor of the building had a library, seminar rooms, a number of private offices and meeting rooms. In the centre of the top floor was a large open plan office. The office was always busy with staff. The team had their own desks and computer terminals.

Emergent themes poly-narrative:

Three themes emerged from the analysis of the case based data. Skill mix and joint working were prominent within this case. Roles and boundaries appeared to be clearly defined; however, there were subtle undertones of jurisdictional issues with regards to which profession should be doing what. The second theme illustrates the concern expressed by all respondents that, as a result of the introduction of the virtual ward service, those patients needing long term rehabilitation or care were missing out. The final theme to emerge illustrates the respondents overall negative perceptions of secondary care. Hospitals were seen as a place which fostered patient dependence as opposed to independence the result being more challenging patients in the community.

Figure 6.6 emergent themes and categories case study four – podiatrist managed locality



Skill mix and joint working

Overall the sharing of skills was seen as a positive thing among the physiotherapists and the nurses. Although not listed extensively, skills were shared predominately in the monitoring of patients' functional or clinical status, for example through chest auscultation, or observation of gait/mobility.

"There are serious advantages to the overlap, which is if you have a patient with chest difficulties, if I'm going in to see a patient my auscultation findings, the next day following the community matron's attendance, then we have two auscultation findings one day after the other," (Band 7 PT).

As the community matron said, through sharing these skills, the team were able to provide a more holistic service.

“It’s a holistic approach to nursing care or to the care delivery I’m giving to a patient” (Community Matron).

An interpretation of the apparent synergy between the nurse and the physiotherapist is that the types of activities they shared fitted into their professional frames of reference and they could see how, through sharing skills their roles and patient care could be enhanced.

In contrast, the occupational therapist felt that skill sharing did not fit into her role in this setting. She acknowledged that through working as part of the team information from colleagues regarding a patient’s function was useful; however she did not feel that it was part of her role to collect this information as part of her day-to-day work.

“There is slight overlap, not major, the physio works on legs, physio will look at mobility; we’ll assess their transfers and highlight if they need stuff, and then for toilet and bed, that sort of thing” (Band 6 OT).

A possible explanation for the sharing of skills between physiotherapy and nursing but less so for occupational therapy was provided by the physiotherapist. He felt that there was more common ground, in this setting, between district nurses and physiotherapists than there was between physiotherapists and occupational therapists. In this setting physiotherapist were concerned with health related needs whereas the focus of occupational therapy was on social issues.

“Social need, health needs, physio defines health needs more as opposed to an OT....I’m not saying OTs do not work in healthcare because that is the evidence that they are there in healthcare, but physios don’t have a role in social care, which goes to tell you that physios are purely healthcare based” (Band 7 PT).

Although possibly narrow, this categorisation of occupational therapy was supported to a degree by the occupational therapist; she recognised that her role extended beyond health, encompassing the social needs of clients. However, this was not her sole role.

“As an OT you can work where I am now where you’ve got ages 18-118, you know, it’s a very wide range and you do all you can do, major adaptations, provision of equipment, rehab, vocational rehab and access to the community” (Band 6 OT).

Picking up and feeding back:

Although the sharing of skills was seen by most to be a positive thing, the extent to which individuals crossed professional boundaries was limited. Unpacking the responses from the nurses and the physiotherapists showed a picture of skill mix which reflected the interpretation provided by the occupational therapist where “there is slight overlap, not major”.

No specific training to facilitate skill sharing was mentioned. Through working together with patients and sharing the same office space an understanding of each other’s’ roles and their own skills had developed.

Through this understanding the respondents felt in a position to identify areas where, for example the district nurse may need to input, or the occupational therapist may need to be involved. When working with patients all respondents recognised the importance of “picking up information” outside of their scope of practice and feeding this back into the team. This however was not performing the same assessment as colleagues from other professions, more “observation of problems”.

“There has been an expansion within my role, as we moved into this new structure, which is taking blood pressure measurements, deciphering more blood results trying to understand, not making judgements on it, but it is an expansion in learning as well as job. In job taking blood pressure, saturation which we normally did within the hospital, often we did not do in community but now we have more of an expanded role” (Band 7 PT).

Problem identification and feedback to the team was something that all respondents said they did. This was partly as a result of the nature of community based work. Depending on the need identified by the referral to the service, any of the respondents could conduct the initial visit. If they were to focus on just their specific area of practice, important clinical information may be missed. It was clear however,

that the respondents were not conducting detailed assessments of clients, as this required specific knowledge and skills which were outside of their remit.

“I wouldn’t say I do mobility, for me it’s more observation, like how quick she took to get out of bed, what is she like when she uses her frame, they’re more observations really, isn’t it? Like you might say, ‘Ok well she used the walking frame but she’s a bit unstable with it’, I don’t know, is that an assessment or just an observation? Or a physio might go in and says ‘Oh when I got her out of the bed she said she had a sore in her bottom’, obvious he’s going to come and tell us, a district nurse.....it’s not that they’re doing an assessment they’re just picking things up and they have to refer it to the other discipline” (district nurse).

Although skill sharing was recognised by the respondents, it is apparent that, as opposed to learning and enacting new skills, the nurses and the physiotherapists were drawing on their existing skills in areas that overlapped between the two professions. The occupational therapist had less scope to overlap and felt that skill mix was not evident in her work. This observation is strengthened by the apparent barriers to skill mix where knowledge, competence and trust were all evident.

Barriers to skills mix

Although it was clear that some skills were being shared between some professions, the respondents raised a number of concerns regarding the expansion of skill mix beyond that of “picking up and feeding back”. The locality manager felt that the primary reason for resistance to skill sharing was

“professional defensiveness...everybody’s frightful of other people taking away what you’ve traditionally done and I think that’s true across many professions” (locality manager case study four).

Surprisingly this professional defensiveness was not strongly identified in the data generated from the clinical staff. This is not to say that it was not there. Both the district nurse and the physiotherapist said that they did not always trust the opinions of colleagues from other professions regarding areas of their work that they considered to come under their specific skill set, something which could be interpreted as defence of jurisdiction.

“I don’t know, that’s just how I am. It might sound like I don’t trust them but if I’m ordering the bed I need to know that they (OTs) know where they’re going to put the bed” (district nurse).

Competence was seen as a barrier to skill sharing. “I am not trained” and “I am not qualified” were cited by the nurses as reasons for not extending their skills or roles.

“I won’t feel confident to assess a patient’s mobility, I would identify that they have mobility problems, but to go into detail , transfers and what the physios do; I won’t be able to do that....because I don’t feel confident, I’m not a physio and I’m not trained to do that” (district nurse).

Respondents were fearful of getting things wrong, making mistakes, if they were to move beyond what they considered to be their profession specific skills.

“I mean you’re going to end up worsening the patient possibly, as opposed to helping them out” (Band 7 PT).

“I’m not trained, I’m not qualified, so if I do something wrong legally I don’t think I’ll be covered, Let’s say someone has had a hip replacement and I teach them rubbish exercises and then something goes wrong, who will be liable for that?” (Community Matron).

Extending this, the district nurse was concerned as to where she would stand legally if she were to do something she had not been formally trained in. As well as competence, confidence was seen as a barrier to expanding roles through the adoption of new skills. As already indicated the respondents were not against skill sharing but due to the lack of specific training or support they did not feel confident to move beyond how it was currently operating.

As well as their own concerns regarding their skills the respondents also noted elements of the organisation which restricted the sharing of skills. An example of this was provided by the district nurse who said that both the nurses and the occupational therapists could order equipment, however the type of equipment that

could be ordered differed depending on your profession. So the occupational therapist could order beds but not mattresses whereas the district nurses could order mattresses but not beds.

Team work – boundaries and jurisdiction

What was evident from the data was that there was a spectrum of autonomy and team work across the two services provided by the respondents (i.e. extended primary care and virtual ward). Of interest is that although all respondents felt that working as part of an MDT on the virtual ward was on the whole positive, it did raise issues of boundaries and jurisdiction over aspects of patient care, and when these arose what could be regarded as traditional hierarchies within the health care professions became apparent.

Within extended primary care the three professions included in the study worked independently of each other. They had their own case loads and managed these individually.

“The significant part of community work remains uni-disciplinary, that’s the bulk of their day-to-day work” (locality manager case study four).

“if someone is referred by the extended primary care and you go and see them and you feel that they could do with a wider MDT input then you can bring them to the virtual ward meeting. Normally if somebody is referred to the virtual ward, be it by the hospital, the GP, those are the two main sources of referral, it is the matron’s role to go and do the initial assessment, feedback to the MDT within the meeting and then we pick it up from there. Normally it’s matron, physio, me depending on what the main issues are” (Band 6 OT). Working uni-professionally the respondents commented that they were individually responsible for screening referrals and accepting patients to their service, setting their own goals and determining when to discharge patients.

Contrasting slightly their work in extended primary care the respondents felt that through working together in the virtual ward they had developed a strong sense of team work.

“we’ve got a good team here, we’ve got a good MDT” (Band 6 OT).

“I think the outcome of a virtual ward is a decision how well we have all done as a team” (Band 7 PT).

Commenting on how referrals are screened in the virtual ward the community matron said:

“the team decides. We get a referral and the referral is presented to the team and the team decides whether the patient is to be on virtual ward or not. If we can’t make a decision on the actual referral form, we will look at what needs are on the referral form and then the best person will go in and see them and come and feedback”

There was also acknowledgement that through the development of the virtual ward, team work and communication in general had improved compared to when the individual services (OT, DN and PT) were based in separate locations within the borough.

“we’re all in the same office so it does make it easier. If you want to refer someone you can talk together, that bits definitely a lot easier and you can just hand the paperwork over, physically hand it over” (district nurse).

“historically therapies used to sit separate, DNs used to sit separate, matrons used to sit separate and there used to be a communication barrier, so referral used to go from one to the other and then the other, it used to take a while. Now as part of extended primary care it does work much better that how we historically worked, we’re sitting on the same floor to shout across the table ‘just give me the NHS number’ and you have another discipline that would go in and see the patient” (Band 7 PT).

Team work was clearly identifiable within the data with respondents sharing responsibility for and being jointly involved in the screening of referrals, goal setting and eventual successful discharge.

Through working together within the virtual ward the respondents had begun to share tasks and began to demonstrate some overlap of roles. This was tempered however as the locality manager suggested when talking about the virtual ward and extended primary care service

“I think actually trying to be a team as opposed to a group of individuals working together, working with one patient but not necessarily together which seems to be what happens in the hospitals. I think there’s a way to go to make it really true that the edges are blurred but virtual ward has allowed us to move on with that”.

The physiotherapist interviewed felt that, although team work was a positive aspect of working in the virtual ward setting his professional autonomy was being challenged. Although accepting patients onto the virtual ward was a team decision often therapy staff were told that they should be involved.

“so it can really get under your skin when someone’s trying to do your job in a way, to tell you to do your job, that OK you are trying to tell me what patient now would come under virtual ward or not come under virtual ward for therapy” (Band 7 PT).

Having to agree on who to see and what targets to set with patients caused tensions. This raised the issue of professional jurisdiction for the physiotherapist who suggested that district nurses or the community matron were not in a position to say who or who did not have therapy needs or what those needs were. Placed in context of the case overall, the physiotherapist felt, that in the virtual ward setting, rehabilitation was being undermined in favour of acute care and as a result of this the community matron was taking the lead on which patients did or did not warrant admission to the service and what their needs were.

“At present the matron or myself, whoever’s present there will triage a referral, but it’s slowly moving to the matrons triaging all referrals including therapy which is really undermining therapy in itself” (Band 7 PT).

Of interest was that the physiotherapist felt assured that when disagreements did arise, then the presence of the GP at the virtual ward meetings was positive, as in his view the GP had overall say in whose view should be favoured.

“Each individual therapists skills differ, what they can identify, what they can interpret, differentially diagnose and then put down as a plan differs, similarly for matrons, I have had concerns but...which is good that we have a GP so we do have a good back up in terms of medical assessment side of it” (Band 7 PT).

Although not interviewed formally the GP from this locality was observed in the virtual ward meeting and was able to clarify some of the points raised by the physiotherapist. In his view, working within the team was a positive experience, his main difficulty was communicating with other GPs, whose patients were brought to the virtual ward.

Rehabilitation losing out to acute:

The second theme to emerge extends on from and reinforces the subtle power relationships exposed in the interpretations of team work and skill mix. As for case study three the allied health professionals expressed concerns that, through the introduction of the virtual ward, their roles had moved from focusing on rehabilitation to more acute care. Unlike case study three, however, these concerns were also shared by the nurses. In addition unlike case study three the respondents in this locality framed their interpretations of a lack of rehabilitation within service reforms and financial constraints, as opposed to professional dominance.

A central role of all respondents working in extended primary care was to help patients be as independent as possible. For the physiotherapist and the occupational therapist this meant identifying clear needs, setting measureable goals and working to achieve these, the primary focus being on maximising function and independence. The therapists saw their role in extended primary care as rehabilitation. A term mentioned by both the physiotherapist and the occupational therapist was quality of life. They felt that through rehabilitation they could improve or maintain a client's quality of life and as a result reduce the need for the patients to access other services (for example reducing hospital admissions).

“Giving them a good quality of life, improving their independence which reflects on their mental health, improves their integration within society and also helps avoid admission. So there are a lot of benefits” (Band 7 PT).

The therapists were realistic in what they could or could not achieve through rehabilitation, for example the physiotherapist suggested that

“it would be unrealistic to get them (the patients) to run if their premorbid level was to walk with a stick and now they’re bed bound” (Band 7 PT).

Rehabilitation was structured in a way to meet both client need and be achievable. The therapist used their specialist knowledge along with the client’s particular goals in order to tailor therapy specific to the patient.

“A gentleman came out of hospital and the hoist they had sent him home with didn’t work and now he is independent from the bed to the wheelchair, and he’s moseying around in his wheelchair. So it is all about needs” (Band 6 OT).

This focus on function and independence was echoed to a degree by the nurses who saw their role in extended primary care as helping their patients to be less dependent on their service.

“The function of our role is to promote independent, we don’t want patient to be dependent on us: if they are dependent on us we try, if we can, for it to be for a short time but sometimes it’s not always because some of the elderly, we’re not time the only professional they would have going in to them to give them insulin and medication for various reason, like their family might live far away, they might not have no family so you’ve got district nurses going in and you’ve got maybe carers from social service” (district nurse).

Again, as with the allied health professionals, there was recognition by the nurses that for some patients this was not possible. A large proportion of their patients were elderly and because of their medical and social issues they were unable to access services other than those of the district nurses and the chance of developing complete independence were unrealistic. Here then, the service offered by the district nurses changed from a focus on rehab, to offering ongoing nursing care for patients in their own home.

The locality manager offered a useful distinction between care and rehabilitation. Rehabilitation was goal directed and time limited, the overall aim being to improve a patient's abilities. Care on the other hand focused on keeping a patient the same level. Through this distinction, the locality manager indicated that care was indefinite.

Although the respondents felt that they had a clear and essential role in promoting patient independence in the community, this was being eroded by changes in how their and other services were managing patients. The most notable change to the way staff based in the locality worked was the introduction of the virtual ward. It was clear from all respondents that they felt as if they were expected to do more for less. From the respondents' perspective the virtual ward patients were seen as an additional case load, another "layer" (Band 7 PT) on top of their already existing case load of patients in extended primary care.

The occupational therapist interviewed was fully aware that over the past three years there had been a real change in community based services. More pressure on hospital beds, resulting in earlier discharges from secondary care, meant more work in the community.

"A lot of the time they come from a certain ward in the hospital and they haven't been seen by OT or physio and are unable to mobilise, transfer, they're just medically stable and they're discharged" (Band 6 OT).

The establishment of the virtual ward could be seen as a reflection of this. The primary role of the virtual ward was to prevent hospital admissions and support early hospital discharges, and in the occupational therapists view, this meant less time for rehabilitation. This was echoed by the nurses who felt that, due to the increase in patients, the need for daily meetings and the additional paper work from the virtual ward, they had less time to spend with patients in extended primary care.

"It all boils down to the same thing, if I'm meant to see..like we got 15 patients on virtual ward and I have to come and feedback so I might end up going to see patients quickly, I'm not saying I will ignore other things, I will not but I may not end up seeing all of them" (district nurse).

Patients on the virtual ward were often acutely unwell and this, plus pressures to prevent hospital admissions, meant that these patients were seen as a priority. With

the introduction of this new service patients requiring rehabilitation in extended primary care were being neglected, as evidenced by the occupational therapist who said that;

“virtual ward are your priority and you can justify cancelling an extended primary care assessment to go and see somebody on the virtual ward: that’s how it’s been set up and that’s how management want it run”.

The roles of the respondents working in the virtual ward changed from one of promoting independence through rehabilitation, to addressing acute medical needs. The types of activities the respondents focused on when working in the virtual ward reflected, to a degree, those of colleagues working in secondary care.

The occupational therapist commented that her input to these patients focused on making them and their carers safe, through the provision of equipment, although her role as an occupational therapist was still recognisable to her. For the physiotherapists his input focused on mobility or chest care. As a response to this increase in acutely unwell patients in the community, the physiotherapy service within the virtual ward had been extended to cover weekends. However this was not the case for the occupational therapists, this reflecting partly their restricted input with these clients and partly that they would not have been able to order equipment for example because other external agencies would not be operating.

Negative perceptions of secondary care:

As in case three, the respondents expressed negative perceptions of secondary care, however, they focused more on the negative impact hospital care had on their patients.

Hospitals were seen as being only concerned with patients’ medical status. The district nurse felt that hospitals made people dependant by promoting or legitimising the sick role, stripping people of their independence.

“Hospital is a dependable place. It is, they put you in a gown and you’re in the sick role” (district nurse).

“Say for instance if we had a patient come out of hospital and they were on a lot of medication, and you know in hospital you’re given the medication so you lose that independence, you’re so used to a nurse giving it to you. So we would go in, we would maybe do it for a week and then what we’ll do, we’ll talk to the pharmacy and get it put in blister packs where he or she can pluck Monday, Tuesday, Wednesday, Thursday and once they’ve got the hang of it, how to give it via blister pack, we’ll pull out” (district nurse).

The physiotherapist felt that hospitals actively restricted the mobility of elderly patients in their wards because they did not have the resources to adequately manage them. This action he felt was clearly against all the research linking mobility to general health and function.

“There is enough evidence out there to suggest that you’re at risk of pressure sores, you’re at risk of chest complications, you’re at risk of muscle atrophy, you’re at risk of normal cardiovascular cardio-respiratory de-conditioning. There’s plenty of evidence out there to suggest that it is not good” (Band 7 PT).

The occupational therapist felt that therapy staff in secondary care did not get the opportunity to engage patients in rehabilitation even if they wanted to. The primary focus of the hospital was to get patients medically stable and then discharge them.

“It frustrates me. I think if I was in the acute setting I’d be very frustrated because your role as such as an OT isn’t to facilitate discharge or a safe discharge, that’s one of the roles, it’s not your sole role. Your sole role is helping people to become independent, or as close as what they were pre-morbidly, but you can’t do that” (Band 6 OT).

The respondents felt that hospitals focused primarily on addressing medical needs, and that once these were sorted out they would discharge patients without fully addressing their rehabilitation or social issues. The occupational therapist felt that a focus on discharge in secondary care was purely financially driven

“the more people the hospital get in and discharge, the more money they get”.

Summary:

The themes and categories identified in this case illustrate the complexity of skill mix and team work. The concerns regarding a lack of rehabilitation mirror those identified in case study three and bring into question the role of healthcare professionals in this context. Finally the respondents' accounts of secondary care reinforce the findings from case study 3 but also the interpretations developed from case studies one and two.

Chapter 7

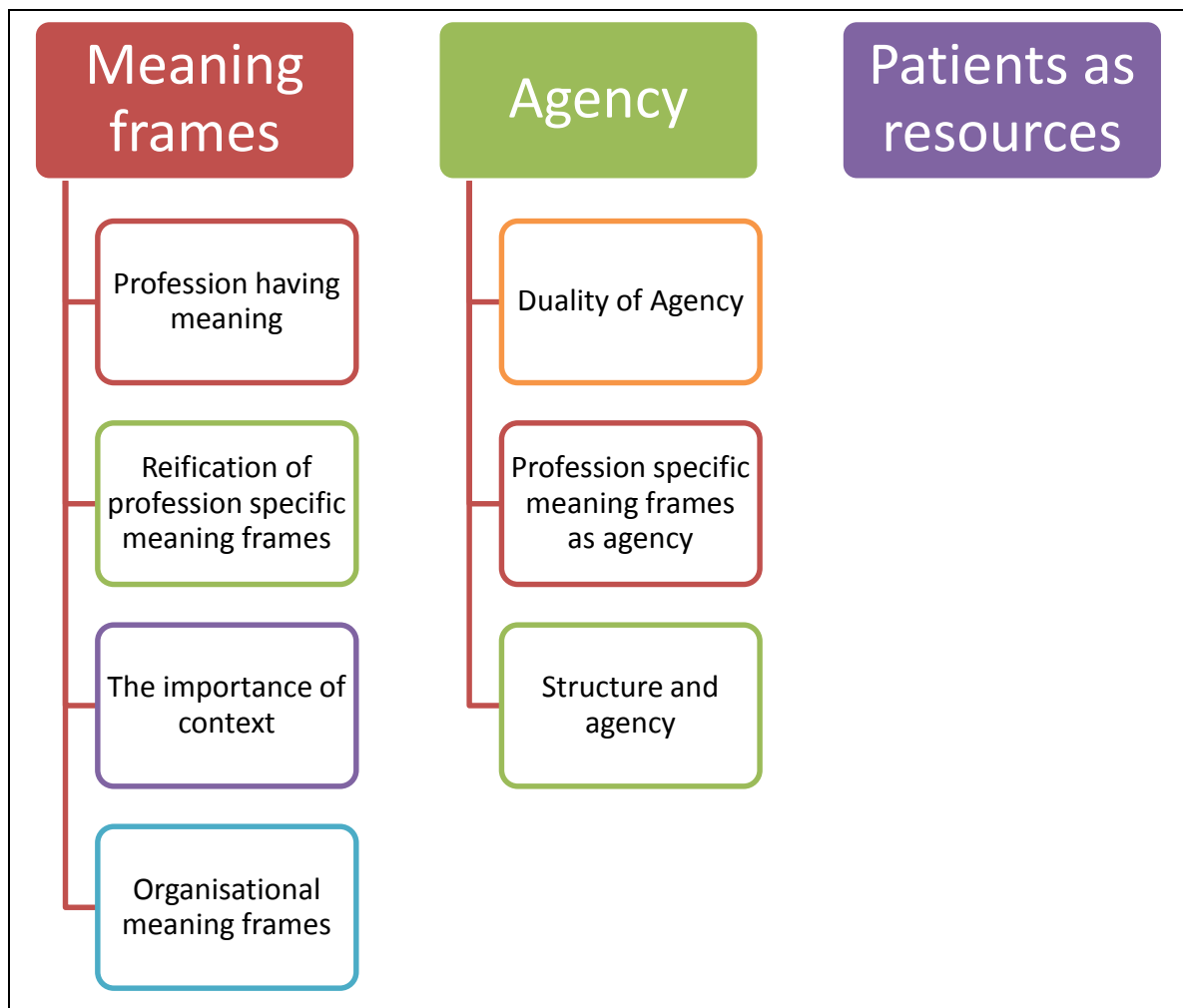
Cross case analysis:

The focus of the case studies was on the praxis of the respondents, the emergent themes providing an account of their day-to-day through the exposure of the mutual knowledge embedded within the themes. This chapter aims to build on the themes identified in the case studies, providing both validity of the analysis and the foundations for theoretical generalisations (LeCompte and Schensul, 1999).

Reflecting the 5th stage of analysis described in chapter 4, the themes developed in the four case studies were interpreted individually and then together within the theoretical constructs derived from Giddens' structuration theory. Analysis across the four cases facilitated the organisation of the data into relationships and patterns and highlighted areas of overlap and divergence. Appendix A section five provides evidence of this process.

Through the process of cross case analysis a number of interrelated themes emerged which form the structure of the chapter. The themes and related categories are illustrated in fig 7.1

Figure 7.1 Themes and categories derived from cross case analysis



It was clear that the respondents drew on multiple meaning frames in order to make sense of their work. The interpretive schemas (Sewell, 1992) accessed by the respondents were constructed from (and contributed to) their profession specific knowledge and skills and the needs of the organisations in which they were working. It is evident through looking across all four cases, that the respondents integrated multiple meaning frames in an attempt to create a coherent interpretive framework, on which to give meaning to their day-to-day work. The extent to which meaning frames were coherent, however, varied across professions and contexts. As well as providing the respondents with an interpretive framework, their professionally and contextually bound meaning frames also gave them access to facilities through which they could enact and defend their social positions. By drawing on frames of meaning, which were defined through profession, and contextually bound knowledge

and skills, the respondents extended their agentic capacity to be able to not only interpret, but also judge their own and others' actions.

Meaning frames:

Across all four cases the respondents drew on a number of meaning frames in order to make sense of and giving meaning to their work as professionals. Professional identity, roles and boundaries are evident and formed by the enactment of multiple meaning frames.

Profession having meaning:

In all four cases the respondents saw themselves as being part of profession specific teams. The emergence of profession as having social meaning is indicative of the social grouping on behalf of the respondents. The social groups identified by the respondents reflected their professional groups. The use of the term “we” to identify a professional group, could be an indication of the collective similarity and belonging for those members of that group (Jenkins, 2007). Logically, however, through the creation of criteria on which members can be identified or identify as belonging to the “we”, there are a set of criteria which identify others as not belonging, those that are different, or “them”. Often in the data sets the respondents referred to “them” to indicate either other groups of health professionals, patients or management. Jenkins (2007, p. 81) has defined social groups to mean a social division which ‘has mutual recognition on the part of its members’, in contrast to a category which, from a sociological perspective is determined by an external. The data suggests that the respondents grouped themselves by drawing on the broader social category of professions. Although not acknowledging it, Jenkins (2007) reinforces Giddens’ notion of the duality of structure, the reciprocal relationship between structure and agency:

How we understand any particular collective identity is an empirical matter, for discovery. In one case group identification may be the dominant theme, in another categorisation, but, both will always be present as moments in the

dialectic of collective identification, even if only as potentialities. (Jenkins, 2007 p 88).

Extending this argument, the social groups existing as identified by the respondents demonstrate the concept of profession as having meaning. Barth (1969) precedes, but mirrors Giddens' assertion that group identities (in the case of Barth, ethnic identities) are a representation of the attributes held and understood by individual members of a group. They are socially real (Barth, 1969; Giddens, 1993; 1984), and thus mean something. The case studies show that the respondents, as social actors, drew on the same concepts as social researchers in order to give meaning to their day-to-day actions. The concept of profession clearly contributed to the formation of a collective identity and sustained a sense of belonging to defined social groups for the respondents.

Reification of professional meaning frames:

As an analytical concept, the term profession had meaning to the respondents however, the concept only gained significance through action (Feldman and Orlikowski, 2011). The concept of profession contained not only attributes and behaviours, but profession specific knowledge and skills, rules of action on which the respondents were able to draw in order to interpret and structure their work.

The distinctions made by the respondents between their professions, and the recognition and acceptance of common knowledge within their own profession, exposed their professional meaning frames. The 'mutual knowledge' (Giddens, 1993, p. 90), reflected in the respondents accounts, provides insight into the structures on which the respondents drew in order to frame their work. These structures not only acted as a reflexive framework, but also provided 'generative rules for interaction' (Giddens, 1993, p. 113).

Across all four cases the respondents drew on knowledge taken from their respective professions in order to describe their day to day practices. Adopting Sewell's (1992) interpretation of structures, and more specifically rules as schema, one interpretation of the mutual knowledge displayed by the respondents across all four cases is as an account of their shared culture in relation to their own profession. This is evident in the recurring theme and concept of skill mix across all four case

studies. Viewing the mutual knowledge as a shared culture allows for a link to be made from and to the concept of professionalism (the behaviours, beliefs, values and practices adopted by a particular profession).

Profession specific meaning frames served as a medium for signifying which elements of practice were important and which were not. Through this process of signification the respondents' were able to legitimise their work in relation to colleagues from other professions, and within the context in which they worked.

The concept of skill mix serves as an illustration of the reification of profession specific meaning frames. The respondents were aware that in their day-to-day practice there were a number of tasks which were shared between professions. The sharing of tasks was evident across all four case studies; however, it was clear that although overlap in tasks was recognised the meaning attached to the tasks by the respondents differed.

Taking the case studies drawn from secondary care initially, in both elderly care and orthopaedics, all three professions intersected and participated in the task of transferring and mobilising patients. The purpose of transferring a patient from the perspective of the occupational therapists was to assess and predict their possible needs once in the home environment; in contrast the purpose attached to the task by the physiotherapists was to ensure that the patients could physically complete the task. What is evident from the data is that it was not the task but the meaning, the purpose attached to the task which was important to the respondents. It was through these purposeful actions that the respondents were able to position their work within the meaning frame of their profession, and in the process distinguish their work from colleagues from other professions.

Different interpretations of the same task were also evident in the cases drawn from primary care. Here the respondents recognised that, although elements of assessments overlapped, their interpretations of the information differed. This difference in interpretations was exemplified by the band seven physiotherapist from case study three. Although she had adopted new knowledge and skills "beyond" her profession, she felt that she interpreted this information in light of her social position as a physiotherapist. The boundaries between the professions were evident in cases

three and four through the act of “picking up and feeding back”. The respondents were highlighting their awareness of their own professional meaning frames but also those of colleagues.

In all four case studies, when talking about skill mix, all respondents used competence as a way of including or excluding themselves from certain activities. Possession (or not) of knowledge and skills, bound to specific professions, was seen as a means of legitimising action (or not). Through this process the respondents’ utilised their profession specific meaning frames to mark the boundaries between professions working in the same context. The utilisation of professional meaning frames to boundary the respondents’ work is exemplified by the barriers to skill mix identified across all four cases, and the tensions between professions within cases. Issues of competence, knowledge and legality demonstrate how the respondents drew on profession specific meaning frames in order to position their work. Knowledge and competencies bound within, and accessible only to members of the different professions, were utilised in order to recognise skill mix. This action also served to reinforce the respondents’ sense of professional identity.

The recognition of profession specific meaning frames, encapsulated in knowledge and skills often led to conflicts of interests. Signifying what was or was not important based on different meaning frames created situations where profession specific meanings were contested and negotiated. As an example applying to all four cases, the allied health professionals positioned their work in relation to their concept of rehabilitation, and in doing so, attempted (some more successfully than others) to legitimise their social positions in relation to this concept. What was evident across all four cases, was that the concept of rehabilitation as perceived by the different professions was often at odds with what the allied health professionals were able to actualise.

Evident in the cases were, what Giddens refers to as, ‘clashes between diverging understanding(s) of common norms’ (1993, p. 117). It was evident that the different professions involved viewed rehabilitation as important; however, they defined and attempted to actualise the concept differently, based in part on their profession specific meaning frames. Where these different interpretations came together differed in the four cases. In elderly care (case study one), the conflict surrounding

the interpretation of rehabilitation was clear in the conflicts recognised between the nurses and the physiotherapists, and in the frustrations felt by the occupational therapists. In orthopaedics, although conflict between professions was not evident, the physiotherapists and the occupational therapists questioned their profession specific meaning frames in light of their social positions. This led the Band 6 occupational therapist to question her profession's role overall. In primary care, it was clear that through the addition of the virtual ward service the allied health professionals questioned the extent to which they were able to engage patients in what they defined as rehabilitation.

Across all four cases the concept of rehabilitation was brought into question. A consequence of this was that power differentials were formed. Of significance was the extent to which the respondents, by drawing on different profession specific meaning frames, had access to, and thus were able to utilise facilities in order to bring to being their interpretation of the concept rehabilitation.

The importance of context on profession specific meaning frames:

The respondents were aware that their social positions were defined by not only their profession, political and economic concerns, but also the context in which they worked. Although the respondents drew on profession specific meaning frames in order to define their social positions and boundaries, they did so by privileging specific elements of these meaning frames in light of the context in which they were being utilised (Wenger, 1998). This is evident in the data, for example in the narratives provided by the nurses in secondary care. What it meant to be a nurse in elderly or orthopaedics was different. This was also reflected by the allied health professionals in this context. The work in elderly or orthopaedics was clearly different for the allied health professionals. The differences were not in what was done, (the physiotherapists worked on mobility, the occupational therapists provided equipment or set up care packages) but in the meaning attached to the activities.

In a similar fashion both the nurses and allied health professionals in primary care defined their work by comparing it to other services and highlighting how "things are different here". This was achieved by comparing and contrasting their work to secondary care. In the case studies drawn from primary care there was a strong sense of cultural significance placed on the respondents work. Highlighting concepts

such as patient autonomy and the lack of physical boundaries, and in describing their negative perceptions of secondary care, the respondents' in primary care depicted a culture in opposition to what they perceived to be secondary care. Through the recognition that things are done differently here, the respondents across all four cases created a contextually bound notion of what it meant to be a physiotherapist or occupational therapist; for example, in orthopaedics or extended primary care.

The recognition of groups within groups has a history in social psychological interpretations of identity (Ashford and Mael, 1989), and has begun to be researched in the growing area of organisational identity (Parker, 2008). From a sociological perspective the concept of context specific identity is locked into the notion of culture and community (Etzioni, 1969; Wenger, 1998). Cohen (2002) viewed culture as symbolic in that it is neither structure nor actions, but meanings which provide the foundations for cultures. The respondents drew on their generic professional meaning frames as well as organisational concepts in order to construct contextually bound, profession specific schemas. The generic rules embedded in the profession specific meaning frames were flexible enough to allow their integration into a number of cultural settings. However not all meaning frames permitted the same degree of flexibility. The tensions experienced by the allied health professionals in all four cases highlight points of incongruence between different meaning frames and point toward how individuals sought to negotiate and enact their social positions.

Organisational meaning frames:

As well as profession specific meaning frames the respondents drew on organisational interpretive schemas exemplified by the needs of the service and the patients within that service. For clarity, organisation is interpreted as the system through which the work of the respondents' was co-ordinated and networked in order to achieve a common goal (Jenkins, 2007; Parker, 2008). The needs of patients appeared to be defined either through their medical condition, as in the case of elderly, orthopaedics and the virtual ward services, or in the case of extended primary care, structured around the goals identified by the patient themselves.

That a common goal existed in all case studies was clear. Within secondary care all the respondents acknowledged that their primary goal was to facilitate a rapid and safe discharge. It was clear through the accounts of their work that the respondents in case studies one and two recognised and contributed to this organisational goal. Within the secondary care, safety was recognised as an organisational goal. In elderly care (case study one) the patients were often acutely unwell. The allied health professionals recognised that hospitals were not the best place for patients with regards to functional rehabilitation. They were also conscious of the general health and financial implications of keeping patients in hospital for extended periods of time. Likewise in orthopaedics, the allied health professionals were aware of the time limits in which they had to work and the targets they had to meet with regards to patient discharges. These broader medical, political and economic frames of meaning contributed to how the respondents interpreted their day-to-day practice.

In primary care, the focus on preventing hospital admissions and facilitating patient independence was recognised by all respondents. Specifically in the virtual wards the focus on acutely unwell patients was acknowledged, and the knowledge and skills utilised by the respondents' reflected this. The division between extended primary care and virtual ward created by the respondents indicated that they viewed their work as being different in these settings. The needs of the patients were different, and this resulted in the perception of two different services. In this way the respondents created an organisational structure which was not intended.

Common in the respondents' interpretations of the multiple schemas shaping their practice was the apparent desire to do the best for the patients. The allied health professionals were aware of the limitations and restrictions on their practice but were able to reconcile these in relation to how the patient benefitted overall. Even though the allied health professionals recognised that rehabilitation was in their view being restricted this was mediated against by positioning this want in relation to the need to reduce risk.

Summary:

- The concept of profession has meaning to the respondents and contributes to the formation of their social positions and to the formation of collective identity.
- Profession encapsulates mutual knowledge on which elements of practice can be seen as significant and legitimate.
- Collective identity within profession specific groups is signified by their enactment of profession specific meaning frames.
- Clashes in meaning frames resulted in conflict between professions.
- Identity, roles, and boundaries are evident through and formed by, the enactment of multiple meaning frames.

Agency:

Concepts of agency are key to understanding the formation of roles and boundaries. Through the process of active reflection individuals drew on a number of rules and resources in order to give meaning to their work as professionals.

Duality of agency:

Extending the concept of agency beyond the primary focus of Giddens' accounts within structuration, but in keeping with the overall notion of duality of both structure and agency, Emirbayer and Mische (1998, p. 970) have defined agency as a 'chordal triad' comprising three interlinked components. The three analytical elements of human agency outlined by Emirbayer and Lische (1998) are iteration (routine practice), projectivity (imaginative generation which allows for the possibility of change in action beyond the routine) and practical evaluation (allowing for judgments to be made in response to changes in context for example). Agentic capacity was evident in the respondents' interpretations of their social positions in relation to the organisation and through their interpretations of the tasks in which they were involved. Social positions and boundaries were constructed by respondents through their active reflection on their day-to-day work. Embedded within the case studies was evidence demonstrating how, through this reflection, the respondents were able to mediate their practice in response to, and as action toward, being able to enact what they considered to be their professional roles.

Through this agentic action, the respondents were able to draw on different rules and resources in order to sustain or develop elements of control over their practice.

The descriptions of the day-to-day practice underlined elements of iterative agency, the routines and taken for granted elements of the respondents work. In secondary care in particular there was clear evidence of process in the work of the allied health professionals. In contrast, in primary care the routine had been challenged. The addition of the virtual ward service and the merger of the teams into localities had created an environment in which social positions were overtly negotiated.

Contrasting the cases from secondary care with those from primary care provided interesting insights into how social positions were mediated through agentic activity.

The clarity of process in both elderly and orthopaedics demonstrated the degree of order and stability in the respondents work. It is important to note that the enactment of routine practice is not passive, it is an active process. This is exemplified in the case drawn from elective orthopaedics. It was clear that the routine and predictable nature of the respondents' work created and maintained a sense of stability between the professions. This is a key element with regards to professional identity. The creation and maintenance of routine practice provides what Giddens terms 'ontological security' (Giddens, 1984, p. 282). This sense of order in the respondents' work served as a basis on which identities could go unchallenged. However, the respondents working in this context were not un-reflexive; they questioned the taken for granted. In order to create meaning and import a sense of projectivity and evaluation in to their work, they looked beyond the application of their professional knowledge and focused on their interactions with patients. Through this evaluative agentic action the respondents were able to legitimise what they did. They acknowledged a lack of professional (judgements regarding the application of knowledge and skills) autonomy in their work, but mediated against this by drawing on alternative meaning frames and structures. Identity, in this setting was formed in part by the relationships the respondents formed with their patients.

To a lesser degree the routines outlined in elderly care contributed to a sense of stability, however, due to the unpredictability of the patients the respondents working in this context needed to employ evaluative agentic strategies in order to orientate themselves to their work. The fluctuating needs of the patients meant that the allied

health professionals needed to deal with ambiguities in their day-to-day practice. A result of this was the need for active judgements in order to negotiate their social positions. One outcome of this was the conflicts and frustrations noted by the respondents in this context. Of significance in this case, and in the case studies drawn from primary care, was the clash of meaning frames underpinning the commutative negotiations and the emergent power relationships between the professions.

In primary care it was clear that the merger of the community based services in to multi-disciplinary teams and the addition of the virtual ward service had led to a disruption to the respondents' routine practice. In order to create a sense of stability in their work and their identities, the respondents actively created a division in the service, based on the needs of the patients. Through their agentic actions the respondents had created a space for iteration (as illustrated by the division between extended primary care and virtual ward). The maintenance of routine and security created a platform on which to form resistance to change (DiMaggio and Powell, 1991).

The changes introduced in primary care produced not only iterative but also projective and evaluative agentic action. Of importance was how agentic action differed across and within cases three and four. In case study three it was clear that the occupational therapist and the band five physiotherapist felt that the adoption of new skills (primarily nursing skills) was being imposed. The band five physiotherapist and the occupational therapist regarded this change as a radical shift away from what they considered their roles to be. They envisaged that by adopting these non-traditional skills that their future practice would be orientated more towards nursing than therapy and judged these changes as negative. This projective and evaluative agentic action resulted in resistance and resentment to the changes. This resistance was developed by drawing on profession specific meaning frames, which were utilised in order to legitimise the respondents' actions. In contrast the band seven physiotherapist in case study three actively embraced the adoption of new skills. Her projected vision of her future practice was one which incorporated and assimilated the non-traditional knowledge and skills in to her practice. One possible explanation for this difference in interpretation is the experience of the respondents. The band seven physiotherapist had over 10 years of clinical experience. It may be that during

this time the band seven physiotherapist had developed a practice based schema which was flexible enough to incorporate the new skills and knowledge. In contrast the less experienced therapists' meaning frames in relation to practice were dominated by a more abstracted understanding of practice.

In contrast the allied health professionals from case study four expressed a sense of control over the changes made to their service. New ways of working beyond the introduction of the virtual ward were not imposed. The respondents in this service regarded skill mix as a positive thing; however, the extent to which the introduction of skill mix affected their routine practice appeared to be minimal. In addition, the introduction of the virtual ward had a familiarity about it; the respondents were able to assimilate this new way of working into past experiences of working in a secondary care setting and as a result were in a position to form a sense of continuity in what they were doing. Although overt resistance to skill mix was not transparent in this case, tensions between professions did arise. The introduction of the virtual ward service and the resulting focus on acute patients had led the allied health professionals to question their focus with regards to rehabilitation. The respondents were able to reconcile the lack of rehabilitation in part, by drawing on the discourses of safety and risk, and in doing so gave meaning to their work.

Summary:

- The respondents' social positions and their boundaries were constructed through active reflection on their day-to-day work.
- A lack of continuity with regards to the patients' condition or how the service is structured facilitates conflict between and negotiation of, meaning frames.
- Extending practice beyond profession specific interpretations may require greater professional maturity on the part of individual agents.

Professional meaning frames as agency

In their descriptions the respondents detailed the scope and position of their work within the context in which they were working. They were able to describe how their practice differed from colleagues' from other professions even though the acts in which they were engaging may have been the same. By doing this the respondents

were identifying the 'markers' used to define their social identities, the 'normative rights, obligations and sanctions' (Giddens, 1984, p.282) associated with their work, which defined their professional roles.

Across all four case studies, the division between the three professions was clear. There were clear separations between the social positions adopted by the allied health professionals and the nurses. By drawing on their profession specific meaning frames the respondents appeared to be claiming jurisdiction over certain activities (Abbott, 1988). Across all four cases the physiotherapists' profession specific meaning frames, privileged knowledge and skills focused toward mobility and manual handling, and as a result they focused their attention on these activities. By focusing on specific tasks the physiotherapists were viewed as being required to fulfil these tasks which in some cases led to conflict (as exemplified in case study one).

The social positions adopted by the occupational therapists in secondary care and the virtual ward environments seemed to be at odds with their professionally orientated meaning frames. The occupational therapists expressed frustration at being only able to enact elements of their profession. This however, did not prevent them taking ownership over discrete aspects of the processes of patient care. In the secondary care setting the occupational therapists had access to the patients' home environment. This provided them with unique knowledge regarding the patient's needs once discharged from hospital. This knowledge facilitated the occupational therapists in influencing the decision making of other professions with regards to discharge planning. In contrast in the community setting such knowledge was not unique. In this context the occupational therapists lacked the capacity to influence their colleagues' work, and in describing their role in the virtual ward setting in particular, expressed frustration in not being able to utilise their profession specific knowledge and skills beyond for example the provision of equipment. Of importance was the recognition by all the occupational therapists interviewed that as a profession they fitted into as opposed to being part of the processes of patient care.

The nurses interviewed defined their social positions as having an overview of the patients' care. They saw themselves as both co-ordinators and providers of care. Through adopting this social position the nurses placed themselves in a position of control. In the secondary care setting the nurses saw themselves as being at the

centre of the wards. They, through their social positions, were with the patients twenty four hours a day and as a result had unique access to information about the patients. In a similar fashion the community matrons had access to, and control over, patient information in the virtual ward environment. In this setting the normative rights attached to the nursing role had created a system in which the community matrons had been given the position of screening all patients coming into the virtual ward environment. However this had not gone unchallenged. The band seven physiotherapist in case study three had actively extended her professional identity by developing nursing skills and competencies. Through this process the physiotherapist had gained access to resources not normally attached to her professional meaning frame and as a result had extended her agentic capacity.

Meaning frames (profession specific norms) developed from, and enacted as, profession specific knowledge and skills, when viewed from the post-Weberian macro theories of the sociology of the professions, could be regarded as attempts to create social closure (MacDonald, 1995), in that jurisdictional claims are made over specific elements of practice. Through the enactment of profession specific meaning frames or scripts (Hotho, 2008) the respondents collectively sought to enhance their professions. This was demonstrated through the signification and legitimisation of their work based on their profession specific knowledge and skills. In this light the respondents could be seen to be contributing to their professions 'professional project' (Larson, 1977), and in doing so were attempting to create a monopoly over certain tasks. Such an interpretation, however, omits the temporal and contextual elements which contribute to the formation of roles, boundaries and identities (Baxter, 2011).

Instead of being in the pursuit of a monopoly or closure the data indicates that the respondents were willing at times to relinquish elements of their profession specific meaning frames, and in doing so, accept the legitimacy of other's interpretations. It was clear that tasks and vocabulary were shared between respondents across all four cases. Outside of profession specific interpretations, the respondents drew on the same rules and resources in order to give meaning to their work. There was at one level, a synergy between the professions. However, the presence of profession specific meaning frames was clear. Where concepts were shared, for example a safe discharge, or a focus on rehabilitation, their interpretation differed. In addition,

although tasks were shared the meanings attached to these tasks differed across the professions.

The social positions adopted by respondents were in part a product of their professional meaning frames. These privileged and legitimised their actions in certain contexts whilst at the same time restricted them in other contexts. The enactment of profession specific meaning frames across the four cases were not uniform, with both contextual and individual differences being evident. The selective utilisation of profession specific norms underlines the notion of professional identity and practice as being a product (in part) of the reflexive individual. What was clear across all four cases was that the respondents as knowing agents chose when to utilise profession specific norms and when not to.

Summary:

- Profession specific knowledge and skills provided the respondents with access to rules and resources and in doing so allowed them to control their work and in some instances the work of others.
- By accessing knowledge and skills beyond those associated with a single profession individuals are able to extend the control they have over their work.
- The division of tasks between professions is not uniform. Through the process of active reflection individuals mediate the use of profession specific rules and resources. The enactment of professional meaning frames is a matter of choice as opposed to one of necessity.

Structure and agency:

Evident across all four cases was the variability with which the respondents were able to enact their profession specific meaning frames. In secondary care and the virtual ward settings the focus of the respondents' work was on the treatment of acute illnesses. In these settings the dominant meaning frame was one which favoured rationales for intervention focused around signs and symptoms. The significance of this lies in the extent to which the profession specific meaning frames held by respondents were seen as meaningful. That is, the extent to which the knowledge and skills possessed by each profession were sanctioned and privileged. It was clear that the physiotherapists drew on knowledge which reflected those of the two largest professions i.e. nursing and medicine. This was underlined by one of the

physiotherapists working in primary care when he said that nursing and physiotherapy were more congruent in their approach to patients, they both focused on health. This degree of congruence between nursing and physiotherapy provided both professions agentic capacity on which they could exert a degree of control over their work. This is not to say that the occupational therapists were powerless. As already indicated in the secondary care context the occupational therapists utilised their knowledge of the patients' home environment to exert influence over their work and the work of others. Of importance was that the occupational therapists (as did the physiotherapists but to a lesser degree) drew on the discourse of safety in order to legitimise their social positions. Safety and risk proved to be powerful rules on which to exert control (McLaughlin, 2001). One clear explanation for this sanctioning and marginalisation through the use of dominant discourses would be to draw on the work of Foucault (1973) and suggest that by adopting a 'medical gaze' or through the discourse of safety, the semi professions gain legitimacy. However the variation seen across the four cases indicates more individual agentic as opposed to institutional action in the creation of roles and boundaries. Across all four cases the respondents actively reflected on their profession specific meaning frames in order to construct a sense of congruency between their social positions and the contexts in which they were enacted.

In primary, care knowledge of the patients' home environment was not unique and although the occupational therapists utilised the discourses of safety and risk, they also drew on other resources in order to provide the markers for their social positions. The occupational therapists in primary care placed great emphasis on their professional networks through the use of profession specific supervision. This strategy was also adopted by the band five physiotherapist in case study three.

Through their individual reflexivity, the respondents were able to detail how as agentic individuals they drew on a number of rules and resources in order to give meaning to their day-to-day practice. These extended beyond their profession specific knowledge, reflecting both institutional and organisational rules. The interaction of the macro, meso and micro rules and resources provided the respondents with greater or lesser influence on mediating their day-to-day practice, as well as in some cases determining the direction of that influence (Greenhalgh and Stones, 2010). Clear, across all four cases, was that an individual profession's

influence was not uniform, underlining the multiplicity (Sewell, 1992) of structures and the duality of structure and agency.

In the case study drawn from secondary care, the allied health professionals and the nurse interviewed were aware that though defining their work as facilitating a safe discharge they were focusing their work away from rehabilitation. This was mediated by the physiotherapists through the importance they placed on rehabilitation in primary care. Through creating a frame of meaning which privileged a focus on a safe discharge they were able to position their work and give it significance within the organisation, yet they were aware of the need for rehabilitation and thus transferred this need into a different context.

In a similar way to the physiotherapists, the occupational therapists placed emphasis on the need for rehabilitation to begin in the primary care context. The occupational therapists also acknowledged how their work met the needs of the organisation through the facilitation of a safe discharge and were therefore able to legitimise their social positions. In addition the occupational therapists through their work, created an environment for the patients in which the need for rehabilitation was removed. Through the provision of equipment and extensive packages of care the occupational therapists removed the immediate need for rehabilitation in their view, and were able to reconcile, to a point, their work. This however did create tensions for the occupational therapists, as evident in their concerns and frustrations regarding their work in this context.

In both cases drawn from secondary care, the need to address acute medical and social issues was given legitimacy over prolonged rehabilitation. The moral claims attached to these were encapsulated in the discourse of safety, finance and risk. Acute conditions were problematised over ongoing rehabilitation through positioning them within the wider context of safety, risk and finance (Miller and Rose, 2008). Safety and risk were seen as not only including clinical risk but incorporated financial and organisational elements. Fear of litigation or of a failed discharge provided strong rhetorical resources shaping the work of the respondents. The allied health professionals actively utilised these concepts in order to exert control over their work but in doing so reproduced and legitimised the lack of focus on rehabilitation. In addition they needed to mediate these claims in relation to their profession specific

meaning frames and so constructed an interpretation of practice which sanctioned their actions.

In primary care, with the introduction of the virtual ward service similar moral claims around the need to address acute issues were in operation. In addition to this the introduction of the enablement service served in part as a rationale for the change in focus of the primary care services. The allied health professionals utilised the concept of safety and risk in order to legitimise the focus on acute patients. Ensuring patients, carers and other professionals were safe was seen as a priority, often to the detriment of providing rehabilitation.

The negotiations for rehabilitation were seen as a point of tension for the allied health professionals working in primary care. The introduction of the virtual ward service was regarded by the allied health professionals as limiting their ability to see patients with rehabilitation needs. However some attempts to mediate against the change in services were evident. The resistance to developing more acutely orientated “nursing skills” expressed by the occupational therapist and the physiotherapist in case study three provided a means of ensuring rehabilitation remained the primary focus of their work. The respondents drew on profession specific supervision as a resource in order to legitimate their actions. In a similar fashion the band seven physiotherapist in case study four drew on professionally oriented meaning frames in order to sanction the need for rehabilitation. As well as resistance the allied health professionals sought to mediate their perceived need to provide rehabilitation through the identification of patients from virtual ward for extended primary care.

As in secondary care the concepts of safety and risk were utilised as a means of forming resistance. There was a sense that through the introduction of the enablement service the scope for rehabilitation offered by the allied health professional in extended primary care had been reduced. In describing the role of enablement the respondents working in primary care drew on the discourse of safety in order to express their concerns. However, interpreting the general resistance to enablement beyond that of the rhetoric of safety provides some interesting insights into the resistance being formed to cross organisational working (Baxter, 2011). The lack of understanding of the role of enablement, the type of services offered and the

credentials of those providing the services all contributed to a general mistrust in what was being provided. Although in its infancy it seemed apparent that, as opposed to multi-agency working the introduction of enablement was deepening divisions between health and social care.

Summary:

- Access to, and the interpretation of, macro, meso and micro rules and resources provided the respondents with greater or lesser agentic capacity.
- It was recognised that as a result of service reorganisations and a focus on acutely unwell patients the opportunity to fully engage patients in rehabilitation was being reduced.
- Discourses of safety and finance provide powerful resources on which agentic capacity can be mobilised.
- Uncertainties regarding the role of other agencies could be a source of resistance to multi-agency working.

Patients as resources:

A key element in the respondents' ability to enact their agentic capacity was their orientation and access to resources. As well as profession specific and organisational structures what emerged from the data was that patients on occasion were also transformed into resources in order to legitimise and signify the respondents' social positions.

Gaining knowledge of and about patients was vital in order to utilise them as a resource. For this to happen, the respondents needed to access the patients. Where access was limited however the respondents sought to redefine the patients in a way which helped to sanction their social positions. In the secondary care cases, as already discussed, the patients were problematised in relation to their acute medical and social needs. Once these needs had been addressed then the priority was to discharge the patients as fast and safely as possible. In order to engage with patients the nurses and the allied health professionals needed to define their social positions as being seen to address these issues.

The nurses, due to their proximity to the patients, had a unique understanding of their day-to-day lives (Svensson, 1996). This was not the case of the allied health professionals. The physiotherapists spent most of their day on the wards; however they were only there during normal working hours and so relied on the nurses to inform them of any changes that may have occurred over night. The occupational therapists, due to the nature of their roles, only spent a limited time on the wards. In elderly care the occupational therapists had limited knowledge of all patients. This was not the case however, in orthopaedics. Here the occupational therapists knew about all the patients on the ward because of their involvement in patient admission.

Contrasting elderly care and orthopaedics it is apparent that due to the processes in place regarding accessing and defining the patients the allied health professionals adopted different strategies in order to control their work and ensure they could utilise the key resource. In elderly care the physiotherapists assessed all patients regardless of whether a referral had been made to them. By doing this the physiotherapists gained knowledge of all patients admitted on to the ward. This facilitated the physiotherapists in mediating what they did in that they were able to control who they saw and when. In addition, by having knowledge of all the patients on the ward the physiotherapists were able to comment on their progress in the weekly ward rounds. Through the utilisation of this knowledge the physiotherapists were able to legitimise their social positions in this context. In contrast, there were fewer occupational therapists and they spent less time on the wards and as a result relied on referrals from the nursing or medical team in order to gain access to the patients. In order to mediate and control this, the band seven occupational therapist screened all the referrals to assess if they were appropriate or not. Through this screening process the occupational therapists were able to orientate themselves towards the resource, defining it in relation to their profession specific meaning frame. In addition to this the occupational therapists utilised their knowledge and skills where they felt they would have maximum effect in achieving the overall goal of facilitating a safe discharge. This strategy however had some negative effects. Often referrals for occupational therapy were made only once the patient was ready for discharge. This left very little time for the occupational therapists to screen, assess and provide intervention and as a result the occupational therapy team working in elderly care felt stressed and anxious about their work.

In the virtual ward setting in primary care, access to patients was also an issue and resulted in the allied health professionals negotiating their input with the nurses. As in secondary care, patients in the virtual wards were there because of their acute healthcare needs. This led the physiotherapists and occupational therapists to orientate their work in a way which addressed these issues. The band 7 physiotherapist in the locality managed by the nurse actively extended her meaning frame in order to provide her with the facilities needed to utilise the key resources in this context. For the occupational therapists in this locality and the allied health professionals working in the locality managed by the podiatrist, accessing patients in the virtual ward was a problem. They were reliant on the feedback provided by the nurses; this resulted again in frustration with regards to their role in this context.

The introduction of enablement was regarded negatively by all the respondents working in primary care. Once discharged from hospital patients were being referred directly to the enablement service for “rehabilitation”. The negative perceptions of the respondents, structured in the discourses of safety, knowledge and competence, could be seen as an attempt to maintain some control over patients in the wider community setting. Through the utilisation of legitimating discourse the respondents were attempting to claim jurisdiction of the primary resource across organisations.

The assertion that patients are seen as resources by professionals as opposed to equal members of the healthcare team is both accusational and paradoxical. With regards to the former, the view that professions seek to gain power and legitimacy through control of patients is to suggest that individual professionals are failing in their altruistic goal. Such an interpretation is paradoxical when positioned in the context of the changes in healthcare policy over the last 25 years, which has, as one of its main agendas, positioned patient centred practice as a central element to reform.

What emerged from analysing the data across all four case studies was the importance context played with regards to how patients were conceptualised. Contrasting the observations made regarding elderly care and virtual ward with elective orthopaedics provides a different interpretation. Of significance is in contexts where roles and boundaries are contested patients are transformed into a facility which can then be utilised to claim signification and legitimacy over areas of practice.

In contrast where roles and boundaries are uncontested then patients become active contributors to the therapeutic process.

The work of the allied health professionals in orthopaedics was more structured. Access to patients did not require mediation as the roles of the allied health professionals were more clearly defined and controlled by the process of care in place. Here the resource/patient was pre-defined by the medical team. The patients had a knee or hip operation and the scope for mediation of the resource was limited. The respondents working in this context were aware of the overall goal and more importantly how through the application of profession specific knowledge and skills they and colleagues from other professions contributed to its achievement. In this context there is evidence of services being orientated towards the needs of individual patients. Professionalism is defined through the positive relationships formed with patients and the difference the respondents made to patients' lives. In a similar fashion when discussing their roles in extended primary care the respondents working in the community placed emphasis on the importance of involving patients in the therapeutic process, promoting independence and tailoring input to meet the specific needs of the patients.

Summary:

- Where roles and boundaries are contested patients are transformed into a resource in order to claim legitimacy over areas of practice.
- Transparent roles and clear goals facilitate patient centred practice.
- The introduction of multiple providers of care could lead to jurisdictional battles over access to patients.

Emergent from the cross case analysis is the subtle interplay of social structures and agentic activity in the enactment of professional roles, boundaries and identities. It is clear that the concepts of profession and professionalism contextualise an individual's work. Profession specific meaning frames enacted through the utilisation of specific knowledge and skills facilitated the respondents in defining their roles whilst also differentiating their work from others. Of importance was that, through their reflexive agency, the respondents' demonstrated choice as to when and how they utilised their knowledge and skills.

The ability to adapt to and mediate between different meaning frames was dependent in part, on the degree of control or power individuals felt they had over their work. Where roles and boundaries were not clearly defined either in service design or in the relationship professions had to patients, then social positions became open to negotiation and in some cases this led to conflict and resistance. In addition, the transparency of roles served to facilitate patient centred practice.

Finally, a key concern for the allied health professionals across all four case studies was that the provision of rehabilitation was, as a result of the focus on acute conditions, being neglected. This concern was reconciled by the respondents through emphasis placed on patient safety. This concern was enhanced by the provision of services by local authorities. The introduction of new providers of services resulted in similar conflicts and negotiations observed at the micro inter-professional level.

Chapter 8

Discussion:

The discussion begins by setting out the findings from the research and their implications. The discussion is developed by locating the research findings in relation to theoretical concepts serving to develop and question contemporary debates regarding the concept of professions and professional practice. The chapter concludes with some critical reflections on the research before highlighting what this work adds to our understanding of contemporary healthcare professional practice, and identifying possible areas for further research.

Research aims revisited:

The aims of the research were to provide contextually bound accounts of the perspectives of allied health professionals regarding their roles and working practices. A number of propositions framed the research questions; the primary proposition was that changes in the structure and context of healthcare delivery have altered the way allied health professionals perceive their roles and boundaries. Individuals' perceptions are, therefore, influenced by the context in which they work. For the purposes of the study design, context was interpreted as the physical location in which allied health professionals worked i.e. either primary (community) care or secondary (hospital) care.

It is important to make clear that although presented as succinct points the findings from the four case studies do not stand independently of each other, underlining the complexity of the phenomena studied.

Firstly, a primary element in shaping roles and boundaries was the complexity of the patients' problems. Where patients presented multiple needs which required input and interpretation from more than one profession then professional roles and boundaries were opened to negotiation. In contrast where the patients' needs were clearly defined and consequently the interpretation of health needs reduced, then roles and boundaries were more stable. The importance of context has been highlighted by a number of authors and has been interpreted and described as meaning the physical location of services (Baxter and Brumfitt, 2008; Crawford et al.,

2008). The data from the case studies challenge this interpretation suggesting that it is the relational, as opposed to the physical, context which shapes professional roles.

It was evident that professional roles and boundaries were formed, in part, through the respondents' and organisations' interpretations of the patients' problems. Further, where patients presented with complex multiple needs then the scope for negotiation of roles and boundaries became greater. Patients seen in both in-patient elderly care, and the community based virtual wards, presented with complex and multiple medical and social needs. A result of this was that the focus of professional work, although framed within a common organisational or service focused goal, varied across professions. In these situations the different professions interpreted and prioritised the needs of patients within their own profession specific meaning frames. What was clear from these case studies was that in the process of patient care, differences in interpretations led individuals to draw on a number of rules and resources in order to justify and legitimise their roles and it was in these contexts that conflicts arose. This latter point is made transparent when contrasting the findings from elective orthopaedics with the acute elderly and primary care cases. In the former, clear protocols for care were in place and inter-professional rivalries minimised whereas in the latter, roles and boundaries were less clearly defined, creating space for negotiation and in some instances conflict. One result of the lack of inter-professional rivalry in orthopaedics was that the professionals' relationships with patients served as a means of legitimising their work more so than in the other three case studies.

The second point derived from the case studies was that where the needs of the patient are clearly defined, not only were the roles and boundaries of allied health professionals clear, but therapists were more patient focused. In contrast where the needs of patients were poorly defined, as in the case of acutely unwell patients or patients who had complex needs, then roles and boundaries, as well as the focus of patient care, was open to negotiation; the latter often focusing on the need to reduce risk.

The data indicates a positive relationship between transparent and structured care and patient centred practice. When framed in the light of current research addressing

professional identities, roles and boundaries reviewed in chapters 2 and 3, this finding adds support to the proposal that in order for professionals to work together effectively towards patient centred practice, clear goals and operational policies need to be in place (Neumann, et al., 2010). By making transparent the aims and processes of care any dormant inter-professional rivalries or power differentials are exposed before services are implemented (Hunter and Segrott, 2008; Fox et al., 2003; Dalley and Sims, 2001). Based on the findings from this research there is, however, a potentially negative aspect of structuring healthcare in this way. The allied health professionals working in orthopaedics questioned their roles as professionals due to the standardised and routine nature of their work. Working with patients who, apart from having undergone elective surgery, were medically well, and whose care was to a large extent pre-determined, removed or at the very least reduced, the need for interpretation i.e. the utilisation of profession specific meaning frames beyond that which had been predetermined. This brings into question the relationship between being a professional as defined through the possession and utilisation of esoteric knowledge and the actualisation of patient centred practice.

The third point to emerge focuses on the respondents' perceptions of team work. The perceptions of teamwork (positive or negative) were determined, to an extent, by how well the needs of the patients had been defined. Where the needs and the goals of patients had been clearly defined, allied health professionals had positive team working experiences. In those cases where the patients' needs were less well defined then the perceptions of team work were less positive. It is important to recognise that it was not just the needs of patients which influenced the respondents' perceptions of teamwork. An individual's perception of team work was also influenced by their recognition and acceptance of the aims of the service overall, in conjunction with their perceived expectations of others.

Across all four cases the allied health professionals and nurses worked in multi-professional teams. The data indicated that individuals' perceptions of team work were a product of the settings in which they worked, as well as how they positioned themselves and their profession, in those settings. Of importance is the recognition that individual professionals were active in the creation and maintenance of positive or negative perceptions of teamwork. Emergent from the data was the utilisation of a number of rules and resources by the respondents in the creation of their roles. As

an example, profession specific meaning frames were evident in the recurrent theme of skill mix and served both as a resource and as a determinant of roles and boundaries. Structuring practice through profession specific meaning frames led to resistance to skill mix. In contrast, drawing on profession specific meaning frames as a resource allowed individuals to position themselves and their work within the wider context. As an illustration this interpretation serves to highlight the complexity of inter-professional collaboration.

The final and most significant point to emerge from this research was that patient rehabilitation in both the secondary and primary care settings was neglected. The long term needs of patients were being disregarded; the focus of allied health professionals across all four research sites was the acute needs of patients, the underlining goal being the reduction of acute risk. This finding serves to highlight an apparent short-termism in the orientation of healthcare services. The findings suggest that changes in the organisation of services, in both the secondary and primary care contexts, have placed emphasis on addressing the acute medical needs of patients. What was clear from the respondents' accounts was that focusing primarily on the acute needs of patients led them to question and in some cases restructure their professional identities. The result for some was a crisis of professional identity (Scholes, 2008).

The perceived lack of rehabilitation, although serving to indicate the focus of healthcare within the cases, brings into question the position of allied health professionals, as experts in rehabilitation, within the settings studied. All the allied health professionals questioned their role in rehabilitation. For some an inability to engage patients in rehabilitation was perceived to be as a result of other professions, for others the structure and focus of the services in which they worked acted as an inhibitor. The former view expressed primarily by physiotherapists, the latter by occupational therapists. The importance of this difference lies in the implication that where physiotherapists felt they were part of the processes of care, the occupational therapists merely fitted in to it.

Evident across all cases was an inherent tension in the allied health professionals' work between the importance they placed on rehabilitation and their ability to enact it. In the case of elderly care and to a degree the primary care cases, an inability to

focus specifically on rehabilitation resulted in conflict between the allied health professionals and predominantly the nurses. Although rivalries between professions were evident, as opposed to being centred on domination and control, the interactions between allied health professionals and primarily doctors and nurses were more reflective of compromise and negotiation. Evident was the presence of a common element of healthcare professional work. In their accounts of their practice it was clear that all the respondents wanted to do the best for patients, and as a result were able to reconcile and compromise elements of their profession specific knowledge and skills. These compromises were reflected in the allied health professionals' recognition and accommodation of the perceived lack of rehabilitation across the four cases.

Evident in the findings is that the permeability of professional roles and identities is not solely determined by organisational or relational factors, but is the result of active choices on the part of individuals. Through active reflection individuals mediated the use of profession specific rules and resources. The enactment of professional meaning frames and the creation of tensions and barriers between professions was a matter of choice. The recognition by the respondents of the changing nature of their practice resulted in both negotiation and resistance. Echoing the work of Mazhindu (2003), the allied health professionals across all four cases recognised the tension between the meanings embedded in their profession specific meaning frames and the focus of their practice. This discussion will be extended by exploring a number of inter-related arguments. These are the concept of professions and professional work, the centrality of purpose embedded in professional work, the normative element of healthcare professions and finally professions as agents of change.

The concept of professions and professional work:

The respondents attempted to re-negotiate and develop their roles by drawing on the often competing, institutional and organisational rules and resources. In addition, the data supports the argument of adaptation as opposed to simple resistance to changes in roles and boundaries. This is not to say that resistance to change was not evident, rather that professionals drew on a number of strategies, with resistance being one of them, in order to make sense of their day-to-day work. The

professional identities created and maintained reflected individual, organisational and contextual consciousness. The work of other authors has proposed that both the ability and or willingness of professionals to change how they work has been attributed to a number of factors. Of prominence is the notion that professional identities and the subsequent roles and boundaries are somehow ingrained, offering little scope for alteration (Crilly and LeGrand, 2004). In addition, concepts embedded within marketisation, for example cost effectiveness and competition, are regarded by some as being fundamentally in opposition to those held by public sector professionals (Hanlon, 2000; Doyle and Cameron, 2000). The findings from this research challenge these propositions.

The participants across all four case studies demonstrated clear but varying abilities in regard to agentic action. In brief, the interplay between structure and agency was apparent in the respondents' accounts of their work and was central to the interpretation and understanding of contemporary professional practice and identity. In addition, the respondents reported a clear commitment to gaining the best outcomes for patients, challenging the proposal that public sector professionals have lost a sense of meaning or purpose in their work. These findings contrast with those found in the work of other authors (Baxter, 2011; Southon and Braithwaite, 1998; Reed and Evans, 1987; Leece and Leece, 2011).

The focus on professional practice, roles, boundaries and identities, has stemmed in part from the proposition that, through enhanced governance and managerial control, the degree of autonomy and power of public sector professionals has been reduced (Foster and Wilding, 2000). A number of authors have suggested that through increased marketisation and managerialism, professions and professionals working in the public sector have been stripped of any agentic action with regards to their practice (Baxter, 2011; Southon and Braithwaite, 1998; Reed and Evans, 1987; Leece and Leece, 2011), and as a result have lost a sense of meaning or purpose in their work. The notion that contemporary professional work has been subordinated by managerialism is captured within the concepts of de-professionalisation or proletarianisation (Barnett et al., 1998), and has been fuelled, perhaps in part, by the negative interpretations of professional practice and professionalism put forward by sociologists (Larson, 1977; Abbott, 1988). Professions and professionalism, in particular with regards to public sector professions, have been brought into question.

Fuelling the debate regarding a decline in professionalism within public sector professions, are the growing number of reported errors or cases of negligence. Public sector professionals have been portrayed as being less focused on the needs of patients and more focused on maintaining professional status or serving the needs of employers (Currie et al., 2009). The altruistic nature of professions has been questioned by both politicians and the public alike (Currie et al., 2008).

Central to many of the reforms in the NHS are the aspirations to create services which place the patient at the centre, permit flexibility and are cost effective. In the pursuit of this, healthcare policies have placed emphasis on the need for professionals to work as teams, engaging in skill mix beyond the remits of single professions and develop leadership skills in order to enact change. Professions however have often been portrayed as being resistant to, or hesitant in, their adoption of organisational principles which seek to address either flexibility or cost (Southon and Braithwaite, 1998). There is also the suggestion that in order to facilitate team working, professions neglect the core principles of patient centred practice such as patient involvement in decision making (Griffiths and Luker, 1994). The dark side (Currie et al., 2008) of professions, namely the pursuit of power differentials, has been seen as a primary inhibitor of the reforms instigated in the public sector over the past 25 years. The findings from the four case studies, although reflecting some of the concerns highlighted, present a picture of professional practice which is more fluid and open.

The data from the four case studies brings into question this conceptualisation of de-professionalisation by arguing that, as new ways of working have been introduced into the public sector, for example through the marketisation of healthcare, professions and professionals are actively adapting to and shaping their identities and developing new ways of working (Miller et al., 2013). One result of these adaptations is a re-casting of the traditional perceptions of what it means to be a professional (Doolin, 2002; Cohen and Musson, 2000; Brown and Crawford, 2003). Central to this interpretation is the notion that professional practice and professional identities are in a state of flux, constantly being reconstructed and negotiated and that individual professionals are knowledgeable agents who 'know a great deal about the conditions and consequences of what they do in their day-to-day lives' (Giddens, 1993, p. 90).

Elaborating on this point, the case study data in this thesis supports the interpretation that the once dominant institutional (in the form of professional bodies) forces guiding individual practitioners have been diluted. The data indicates that the creation of a multitude of stakeholders representing institutional and organisational agendas now contribute and compete in the formation of professional roles (Jones and Green, 2006; Grant et al., 2009). The notion of entrenched professionals, drawing on their professions in order to claim and retain jurisdiction over elements of service delivery is questioned. Such an interpretation is in keeping with the recent focus on the temporal and contextual nature of professional practice, (Baxter, 2011; Crawford et al., 2008; Reed and Anthony, 1993). Professionals working in the “new” NHS now, therefore, have to mediate between multiple stakeholders in order to shape and interpret their work (Moffatt et al., 2013).

The centrality of purpose:

In interpreting the findings across all four cases it was evident that the concept of profession had meaning and contributed to the formation of the respondents’ social positions. In addition to this, through the enactment of professional specific knowledge and skills, the respondents actively generated a collective identity. By selectively drawing on elements of their profession specific meaning frames, the respondents were able to signify and legitimate their social positions. The meanings attached to their work were the production of their reflexive sense making (Cox et al., 2003). Through reflecting on their work the respondents were engaging in a continual process of readjusting ideals and principles in order to give meaning to their work (Banks, 2010). Of importance, was that when challenged, the respondents drew on moral interpretations of conduct and commitment in order to make sense of their actions and interactions.

It would appear that a fundamental element in the construction of professional identities, roles and boundaries is the importance placed on meaning in the interpretation of day-to-day practice. By drawing on multiple social structures, rules and resources (Sewell, 1992) individuals attempt to legitimise and signify their actions and in doing so create space for control or as Giddens (1993, p. 118) describes ‘transformative capacity’ over their day-to-day work.

Professional reflexivity:

Neither context nor profession are the sole determinants of action, rather it is the interplay between individuals, their environments, and the social structures (rules and resources) they have access to, which shape the meanings individuals give to their work. This interpretation lends support to the work of a number of authors who have moved beyond the view of professional action as simply being the reification of scripted abstract accounts of professional work, but who place emphasis on individuals and their reflexive capacity (Mackay, 2007; Carmel, 2006). To view professional practice in its abstract sense is to divorce individuals from their work and devalues the reflexive element of professional work. This interpretation reinforces the importance of making space for reflective practice in both the education of professionals, but more so in the ongoing development of professionals within organisations (Clouder, 2010; Paget, 2002).

Central to the respondents' accounts of their work across all four case studies was the meanings they attached to the tasks they undertook with patients. Interpreting the significance of meanings necessitates their contextualisation, and as such moves the focus beyond just meaning, to purpose. Purpose, exposed through the meanings attributed to actions (Giddens, 1993, p. 93), could be regarded as being derived from profession specific, organisational and contextual meaning frames. Meaning, the values and commitments expressed by the respondents through the descriptions and enactment of their work, was formed from, and formed, the social interactions between individuals and their social cultural context (Mead, 1964). Professional identity and associated roles could be seen to develop as a process of social and individual reflexivity. Fagermoen (1997, p. 435), interpreting Mead's work in the context of nursing identity, suggested that through the process of reflexivity individuals internalise values, which she argues are 'structurally essential components which are used as the major frameworks that undergird actions in the social context'. Fagermoen's assertion is that through the internalisation of values, individuals develop a moral commitment or attachment to these values and thus are able to derive meaning from their work. The fluidity of the respondents' accounts of their roles and boundaries presented a more nuanced account of meaning, questioning a moral commitment to action.

The relationship between morals and purpose with regards to healthcare professionals has been discussed extensively in relation to medical ethics (Beauchamp and Childress, 2001; Purtilo and Cassel, 2005). However, when interpreted in light of sociological theories of action and interaction, Fagermoen's interpretation could be regarded as reflecting Durkheimian views which suggest that the decision to act in a certain way is an inherently moral one (Stones, 2005), the moral elements being both a reflection of societal norms and individual commitments. With regards to identity formation, the interpretations outlined above indicate that by attaching moral meaning to activities, individuals are able to ground their identity within both self and societal norms (Weinreich and Saunderson, 2002) (and in the case of professional identity, professionally accepted norms) and in doing so are in a position to distinguish their work from others (Reynolds, 2007).

As indicated, the data from the four case studies demonstrated a more reflexive interpretation of practice on behalf of the respondents. Giddens (1993) has taken a more utilitarian approach to the moral interpretation of meaning and purpose. Rather than action being seen as an expression and result of a moral commitment, Giddens argues that our actions are a result, and expression, of our reflexive interpretations of a range of possible obligations and sanctions. Giddens' assertion is summed up thus 'it is an elementary mistake to suppose that the enactment of a moral obligation necessarily implies a moral commitment to it' (Giddens, 1993, p.115). Our focus is on potential outcomes, actions being the result of an active reconciliation between different meaning frames, and the potential obligations and sanctions they may imply. The data from the four case studies adds support to this interpretation and allows for the opening up of professional practice beyond "rules based" interpretations.

Echoing the divergent views of the relationship between morals and purpose, Banks (2010), discussing integrity in social work professionals, has proposed three interpretations of the values professionals draw on in order to give meaning to their work. Due to the limited literature concerning professional integrity Banks constructed her troika on broader philosophical interpretations of moral action. Interpreting Banks' work, in relation to the moral interpretation of purpose, leads to the suggestion that the meanings attached to professional work are a reflection of conduct, commitment and capacity. Conduct refers to deriving purpose from

accepted professional guidance, professional work is meaningful and morally correct if it conforms to publically accepted interpretations of professional work. Commitment places emphasis on the individual's personal beliefs which go beyond professional guidance. Finally, echoing Giddens' account of the moral interpretation of purpose, capacity or moral competence privileges the agentic action of individuals in their continuous interpretations of social interactions. This final interpretation has been described by Cox et al., (2003) as the perpetual reflexive sense making of individuals permitting them to give meaning to their actions.

Power and control:

Evident from the cross case analysis is that clashes of meaning frames were prominent in those cases where roles and boundaries were open to negotiation. This occurred in environments where the patients' conditions were complex and changeable for example in elderly care or the virtual wards. It was in these contexts that the profession specific wants or interests were brought to the fore, a process which revealed the differentials in transformative capacity. Where the ability to pursue interests was threatened, the respondents drew on multiple rules and resources in order to maintain a degree of control over their work. However, in some cases, where the power differentials openly privileged one profession over another, resistance was formed. This was most obvious in the primary care case study managed by a nurse and echoes the concerns raised by Robson and Cottrell (2005) regarding inter-professional working where power and status are seen as a source of conflict between professions.

Of importance in developing the argument regarding the meanings attached by the respondents to their practice is the consideration of power and control which is so often associated with the work of professionals (Johnson, 1972). Embedded within the concept of meaning is the notion of interests or wants which are directly related to the outcomes individuals seek to achieve through their day-to-day actions and interactions (Giddens, 1993, pp. 92-93). Giddens de-emphasises power within agentic action, placing more emphasis on the concept of transformative capacity. The delineation of power, within the broader concept of transformative capacity, allows for a more fluid interpretation of human action and interaction beyond that of just conflict and resistance, to one where multiple meanings and hence negotiations

can be interpreted. Viewing agentic action as the pursuit of interests as opposed to merely the acquisition of power or control over others, brings to the fore the mediation of multiple meaning frames shaping the day-to-day actions demonstrated in the respondents' accounts.

This interpretation of power in relation to professional practice moves beyond the more uni-dimensional interpretations put forward by Abbott (1988) and Larson (1977) which suggest that the primary purpose of collective professional action is that of control. It is worth noting that both Abbott and Larson based their interpretations of professional practice on the medical profession which is often regarded as possessing all the desired attributes allocated to a mature profession. In contrast the semi-professions (Etzioni, 1969) are defined as having less access to and control over the rules and resources associated with health care and as a result actively negotiate their transformative capacity. In light of the case study data, the stance that the distribution of power between the "semi" professions is in a state of flux and open to interpretation, is more applicable than the more macro interpretations of dominance and control.

The meaning frames exposed in the data were the product of negotiations which formed practice/action and were also the product of differences in transformative capacity. Of importance is the recognition that the greater an individual's transformative capacity i.e. their ability to pursue their interests unabated, the more concrete their meaning frame, and this has a direct influence on what is accepted as socially real. As Giddens (1993, p. 120) argues 'what passes for social reality stands in immediate relation to the distribution of power'. Where reality is contested there is scope for mediation. The significance of this lies in the relationship the allied health professionals had with nursing and medicine.

Another important element in the discussion regarding transformative capacity and its relationship to action is the division between conflict and contradiction. Negotiations cannot occur where meaning frames and the interests embedded within them contradict, as this represents direct opposition. However, where meaning frames differ yet are created through the utilisation of the same structural principles then negotiation can occur. As Giddens argues 'conflict, in the sense of active struggle pursued in the context of clashes of interest, is a direct property of

interaction' (Giddens, 1993, p. 131). The recognition that allied health professionals across all four case studies were involved in negotiation indicates the presence of shared or common elements of healthcare professional practice.

The implications of this interpretation of professional interactions are twofold. First is the contention that any investigations focusing on professional practice need to move beyond a simple linear interpretation of power and control, in order to expose the subtle interrelations and negotiations between individuals in the formation of roles and boundaries. The second implication centres on the synergy across professions, as expressed as the normative element of healthcare professional work, and the relationship different professions have to this.

Negotiations and the normative element of healthcare professional work:

The respondents across all four case studies drew on multiple meaning frames in order to give salience to their work. Of importance is the commonality in rules and resources utilised. All respondents drew on the discourses of safety and finance in addition to their own profession specific meaning frames. In the case of the latter, although facilitating differences in interpretation, what was apparent across all four cases was the presence of a universal or normative element to the respondents' work.

Interpreting the respondents' ability to reconcile often conflicting meaning frames is the assertion of a shared want. A central element embedded within the purpose and meanings attached to the work of the respondents was the desire or want to help patients. Although common, however, the interpretation and pursuit of this want when translated within profession specific meaning frames led to the privileging of distinct elements over others. What it means to help patients differs across professions, as the interpretations of a patient's problems were encoded within profession specific knowledge and skills. Again this was most evident in the case studies focusing on elderly care, and the virtual wards where the needs of patients were open to interpretation i.e. where patients presented with multiple complex medical and social conditions.

The negotiations and conflicts as discussed in relation to the four cases, serves to highlight the commonality, or structural synergy, between the rules and resources

utilised by professionals in order to give meaning to their day-to-day work. In addition, the interests or wants of the respondents, although appearing to differ between the professions, showed elements of synergy and it was only because of this synergy that negotiations could occur. The normative element of healthcare professional work therefore is the recognition that they should reduce risk, and more specifically risk to life.

The acknowledgment of synergy between professions is not surprising when one considers the development of the semi-professions within the healthcare context. Through the development of models of practice, nursing, physiotherapy and occupational therapy have provided professionals with a shared image of what it means to be a member of each profession respectively (Reilly, 1975), and by doing this have illustrated where the three professions intersect with regards to the focus of their work. A model of practice has been defined by Reichl and Roy (1980) as

a systematically constructed, scientifically based and logically related set of concepts, which identify the essential components of nursing practice, together with the theoretical bases of these concepts and the values required for their use by the practitioner.

Although being defined in light of nursing this broad definition is equally applicable in principle to both occupational therapy and physiotherapy (Cott et al., 1995; Kielhofner, 1997). Reflected across all three professions is the need to place the patient at the centre of the therapy process, the integration of biomedical and psychosocial elements, and an acknowledgement of the temporal and contextual nature of healthcare and illness.

Detailing the concept of a normative element to professional practice, Halliday (1985), proposed that professions could be broadly separated and defined based on their core epistemological values, or as Halliday termed their 'cognitive core'. Halliday contrasts medicine with Law in order to illustrate the distinction between those professions which have a science or fact based core with those that have values at their centre. Of importance with regards to interpreting the data from my research is Halliday's argument that by drawing on their cognitive core, professionals are able to influence others in order to get them to act in a certain way. Halliday's (1985) argument asserts that those professions with a scientific core would utilise

this in order to legitimise their actions, bound their work, and when possible control the actions of others. Contesting this, the interpretations made from the four cases in this research suggest that values as opposed to simply facts serve as resources for professional influence. The boundary work of professions formed through the assertion of facts is eradicated through the utilisation of moral claims of legitimacy.

The data generated from the four case studies indicates that in order to claim legitimacy, nurses and allied health professionals draw on medical ideologies and in doing so appear to neglect or downgrade core aspects of their professions. The dominance of the medical ideology, more specifically the normative element of the want to reduce risk to life, brings into question the expansion of healthcare practice to accommodate more socially orientated paradigms of health care and as part of this, the drive for patients to take more responsibility for their own care.

In the practice of physiotherapy, occupational therapy and nursing, a number of authors have been critical, accusing these professions of being disloyal to these core principles in their attempts to gain legitimacy and credibility. It has been suggested that both physiotherapy and nursing (in the context of acute care) fail to adhere to the principles outlined above, favouring a more biomedical interpretation of health (Nicholls and Gibson, 2010; McCaugherty, 1991; Henderson, 2002). The data from the case studies, in particular those from secondary care and the virtual wards, support this criticism. One explanation for migration toward a more biomedical interpretation and focus of practice could be in part the historical relationship nursing and the allied health professions had to medicine. Nursing has attempted, and continues to distinguish itself as a profession and differentiate itself from the ideology of medicine, although the effectiveness of this remains questionable (Henderson, 2002). Reflecting on the progress and development of physiotherapy, a number of authors have concluded that since its conception as a “recognised” profession, physiotherapy has modelled its practice on medicine (Miles-Tapping, 1985; Sim, 1990; Roberts, 1994). This adoption of medical concepts in the shaping of physiotherapy has led Nicholls and Gibson (2010) to suggest that the core values of medicine, for example a focus on aetiologies, generic diseases and the need for scientific neutrality still permeate through much of the profession’s values.

The synergy between physiotherapy and nursing was reflected in the case studies; in addition it was clear that although occupying the same space, the occupational therapists sat outside of the processes of care. An explanation for this is provided when, as for nursing and physiotherapy, the relationship occupational therapy has with medical ideologies is taken into consideration. In contrast to both physiotherapy and nursing, occupational therapy, arising out of the US, had at its focus the value of everyday activities, divorced from isolated medical conditions. Emerging not from medical care but from the more socially rooted moral treatment movement, occupational therapy has reflected more socially and psychologically seated conceptions of rehabilitation (Barris et al., 1988). Over its development as a profession however, a number of authors have suggested that in order to gain legitimacy and credibility, the profession, as a whole, has adopted elements of the dominant medical ideology (Rogers, 1982, Barris et al., 1988). The more abstracted relationship occupational therapy has to medicine has led Fortune (2000) to suggest that only through divorcing itself from some of its founding principles surrounding occupation, the profession has been able to fit into a model of practice dominated by medicine, the result being that occupational therapists' act as 'gap fillers' (Ibid) between health and occupation.

Central to the development and maintenance of the semi professions is their relationship to medicine. Although recognised for some time (Friedson, 1990), the dominance of medicine has been questioned over the past twenty five years. The introduction of marketisation and managerialism into healthcare has led some authors to suggest that the autonomy medicine had over its knowledge base and practice has been eroded (Barnett et al., 1998). In addition, the authority medicine once held over the semi-professions, seen as an indicative element of medicine as a profession, has been challenged as professions such as nursing and the allied health professions have sought to extend their practice into areas once occupied by medicine (Borthwick, 2000). This dilution of medical authority and the expansion of autonomy beyond medical control by the allied health and nursing professions have been facilitated by recent changes in policy emphasising the need for non-medical professions to adopt new roles (DoH 2008a). However although it may be the case that the roles of nurses and allied health professional have expanded, this has only

occurred as a result of them making their contribution to the normative element of health care professional work conspicuous.

Lack of rehabilitation:

The acknowledgement of the normative element of professional practice is underlined by the reported lack of space for rehabilitation in both the secondary and primary care settings, and the ability of the allied health professional to reconcile this. It was clear that the role of allied health professionals in the secondary care context was to facilitate a safe and quick discharge. Space for rehabilitation in this context was limited, however this was reconciled to a point by the respondents' assumptions that once discharged, further rehabilitation would occur. In addition to this the respondents in this setting were able to reconcile their actions and give meaning to their work by drawing on the normative element of healthcare professional practice. This insight into the focus of therapy in the secondary care setting echoes that presented by Masley et al., (2011), where safety and facilitating a quick discharge were shown to be a priority, and underlines the focus of secondary care services. Within the case studies, the lack of clarity of purpose contributed to the crisis expressed by some regarding their roles and identities.

With reference to the cases drawn from the community, changes in the structure of the services in the primary care had resulted in patients deemed as requiring rehabilitation being downgraded in favour of patients with acute medical conditions. This occurred as a result of the introduction of the virtual ward service alongside the existing extended primary care. As in the secondary care settings the allied health professionals in the community were able to reconcile this lack of rehabilitation in part by drawing on the normative element of healthcare practice. Again however, the lack of clarity regarding the purpose of community based services contributed to the inter-professional rivalries and the questioning of roles and boundaries expressed by some respondents in this setting.

The lack of rehabilitation expressed by the allied health professionals in both the community and hospital settings raises a number of issues when placed in the context of the four case studies as a whole and in the broader reforms being introduced into the NHS in England. What is clear is that a lack of clarity with regards

to the purpose of services, whether these be primary or secondary care, contributes to inter-professional rivalries and crisis over professional roles and identities. It could be argued therefore, that in order to facilitate inter-professional working, clarity of service provision is paramount (Xyrichis and Lowton, 2008; Goodman et al., 2012; King et al., 2013).

Agentic professional:

All respondents across the four case studies drew on multiple meaning frames in order to give meaning to their work. Common across all four cases were the discourses of safety and finance and by drawing on these structural concepts the respondents were able to position their work within the context of the organisations they were working. As opposed to professional identity, roles and boundaries being singular, defined only through the enactment of profession specific concepts, they are in fact an ongoing product of the integration of multiple meaning frames (Ball, 1999). The extent to which individuals extended their conceptualisation of practice appeared to be dependent on the scope for mediation, and to a lesser extent the maturity of the professional (Axelsson and Axelsson, 2009).

Evident were variations in the extent to which individuals across the cases were seen to integrate or not, multiple meaning frames in the formation of their professional identity and subsequent roles. Whitechurch (2008), conducting research into the professional roles and boundaries of teaching professionals in higher education, has proposed that professional identities, roles and boundaries can be delineated across four broad categories. Professionals whose work could be seen as adhering to clearly defined professional roles, have been categorised by Whitechurch as bounded professionals. In contrast individuals who actively extended their roles by either crossing or disregarding boundaries were classified as cross-boundary and unbounded professionals respectively. Finally, Whitechurch proposed a third space in which professional identities can develop. The third space being characterised as being located beyond formal structures. Whitechurch (2008) argues that individuals who can be classified as being cross-boundary, unbounded or third space professionals are best placed to 'build strategic advantage and institutional capacity' (ibid, p 382).

The extent to which Whitechurch's taxonomy is reflected in the data gained from the four case studies is variable. Evidence of bounded professional identities and roles is clear, especially where the opportunity for mediation is reduced, or where resistance is formed in the response to change. Where scope for mediation was evident then cross boundary professional identities become apparent. However, there is little evidence of either unbounded or third space professional work across all four case studies.

Focusing on those contexts in which mediation of professional meaning frames were apparent, it is clear from comparing the four case studies, that where a patient presents with complex medical or social needs, then the scope for negotiation and integration of meaning frames is increased. In contrast where there are clear processes of care in place, or where a patient has a clearly defined medical need, then the need for mediation is reduced. Of importance, however, is in cases of the former, where multiple interpretations come into being, an environment is created in which power differentials between individuals and professions are brought to light. Once power differentials are made transparent then individuals adopt a more cross-boundary identity in order to give meaning to their work and in doing so enter into negotiations as to the achievement of often competing interests.

The value of these negotiations lies in the ability of professionals to reflect on and choose to reconcile differing interests in order to achieve what is best for patients, for example by mediating against the possibility of discourses such as differing conceptualisations of safety or finance adopting a position of dominance. However, through these processes of negotiation, and the resultant power struggles, patients may become less of the focus, being replaced by the "wants" of increased transformative capacity or the avoidance of sanctions, for example through the maintenance of the status quo (Griffiths and Luker, 1994). In contrast where the space for negotiations is limited, patients appear to become the focus of professional work, however, the extent of transformative agentic action is reduced. There is a dichotomy with regards to the development of cross boundary or boundary less professional identities and patient focused practice.

It can be argued therefore, that in order for organisations to facilitate professionals to cross boundaries, yet still remain focused on the needs of patients, the latent power

differentials need to be made transparent. In addition emphasis needs to be placed on the shared values across different professions as a framework for structuring discussions. Finally acknowledgement of and space for reflective practice is essential to allow professionals to mediate and reconcile the multiple meaning frames which shape and are shaped by practice in order to avoid resistance.

Taking account of power differentials alone may not fulfil the goal of unlocking the potential of agentic professionals. Based on the case based data it would appear that a second environment in which cross boundary work becomes achievable, is where there is professional maturity on behalf of the individual. It would be prudent to suggest that in order for individuals to be in a position to extend their professional identity beyond their immediate professional boundaries, a degree of experience is needed. Wenger (1998) recognised the importance of experience in his assertion that experience of meanings was essential in order to fully participate in a practice environment. Extending this, Axelsson and Axelsson (2009), commenting on the literature concerning professional organisation, leadership and collaboration, and supported by case study data from the field of vocational rehabilitation, have argued that in order for individuals to recognise the contribution of other professions or agencies they need to have 'a great deal of professional maturity' (Ibid, p. 325).

Within and across the case studies was evidence of individual interpretations of practice, which were a reflection of a number of meaning frames. The assimilation of divergent meaning frames may be as a result of the development of professional maturity. As a concept, professional maturity has been identified across a number of professions (Lee, 1971; McKeachie, 2007). Embedded within the findings from a qualitative meta-synthesis on the concept of caring in nursing, Finfgeld-Connett (2008) reported that the concept of professional maturity was reflected in attributes such as a well-established knowledge base and high levels of competency. In addition professional maturity was closely associated with the ability to cope both psychologically and physically with the emotional demands of clinical work. Although sharing elements with the concept of professional expertise (Boshuizen and Schmidt, 2000) the concept of maturity places emphasis on an individual's social competency within the professional role.

Professional maturity has not been extensively developed within the allied health professions literature, however, there has been some discussion directed toward the concept of maturity in light of the professions generally (Bennett and Grant, 2004; Fortune, 2000). Where professional maturity has been identified within the work of therapists it has emerged from accounts where therapists are involved in emotionally demanding practices (Gray and McPherson, 2005). Recently empirical work reported by Adam et al., (2011) focused on the knowledge, skills and behaviours utilised by occupational therapists and physiotherapists in the work of ergonomics and occupational based injuries. Adam et al., proposed that in order to be effective therapists needed to possess maturity and judgement in order to cross boundaries and address the needs of complex clients.

Referring back to the attributes associated with maturity as identified by Finfgeld-Connett (2008), there has and continues to be extensive literature regarding the value and importance of critical reflection on the part of members of the therapy professions, an activity which has been associated with professional maturity (Carlson et al., 2005). The identification of professional roles and boundaries being formed in part by the reflexive individual, points toward the notion of professional maturity being the product of, and formed through, reflexive action.

Leadership is currently seen as a desirable attribute of healthcare professionals. The need for individuals working in healthcare to be not only clinically competent, but also possess sufficient knowledge and skills to enable them to acknowledge, assimilate and act upon political, financial and governance issues has been championed by both policy makers and academics alike (Hartley and Benington, 2010; Shapiro and Rashid, 2011). A key question for future research to address therefore, is the association between professional maturity and leadership skills.

Limitations:

A key element of qualitative research is the centrality of interpretation and with this the notion of contingency. The acceptance of contingency however does not mean that qualitative research cannot be questioned or judged. Throughout the research process issues of quality and rigour have been questioned and approaches adopted in order to address these questions. Reflecting on the overall quality of the work in

light of the criteria outlined by Tracy (2010) a number of limitations regarding the quality of the research process have been identified. Practical limitations such as extended time in the field, the lack of member checking by all respondents and the lack of inclusion of extensive data sources beyond scheduled observations and interviews all serve to limit the overall rigour of the work. Although thick descriptions were provided through the creation of poly-narratives, limited and intermittent time in the field resulted in a shortcoming with regards to capturing the temporal elements of the case studies. One consequence of this is a uni-dimensional perception of roles and boundaries. It is accepted that the use of observational data has mediated to a degree against this; however a lack of robust data triangulation serves to bring into question the overall credibility of the findings.

Although a rationale has been provided as to the adoption of a particular theoretical stance, the influences of this on the overall interpretations of the data are recognised. The use of theory, in particular elements of Giddens' structuration theory facilitated the cross case analysis and the development of conceptual interpretations. Yet the privileging of one interpretive framework over others restricts to a degree the overall theoretical transferability of the findings.

Areas for future research:

This research has raised a number of issues which warrant further investigation. To begin, the relationships between clarity of service, patient need, inter-professional working, professional roles, boundaries and identities, and patient centred practice is an area of growing interest. The data from this research indicates the complexity of these elements and in doing so challenges some contemporary interpretations of healthcare professional work. This work would be advanced through the adoption of methodologies which permit the complexity of professional practice to be exposed whilst taking into consideration the temporal as well as contextual elements. Such grand narratives which focus on micro, meso and macro elements of healthcare professionals' work would serve to challenge or confirm this study's findings.

At a more granular level this research has proposed a number of concepts which contribute to the formation of professional roles and boundaries and as a result influence patient care. To begin, any investigations focusing on professional practice

need to move beyond a simple linear interpretation of power and control in order to expose the subtle interrelations and negotiations between individuals in the formation of roles and boundaries. The application of different theoretical interpretations of power such as those proposed by Foucault would enhance understanding in this area. In addition attention needs to be directed toward patient focused as opposed to profession focused working, the latter privileging professions over patients. The demonstration of a normative element of healthcare professional work warrants further investigation. The delineation of professional identities based on the taxonomy proposed by Jenkins (2007), taking account of professionalism, professional and professionality developed in this work provides a framework in order to unpack areas of congruency between professions. Exposure and articulation of shared elements of healthcare professional work may serve to provide a framework for structuring and promoting greater inter-professional working, and as a means of facilitating discussions around service provision. Finally, acknowledging the findings from this work are based on only four case studies emphasises the need to question the role of rehabilitation in both primary and secondary care, and the potential effects current changes in service provision may have on patients future healthcare needs. Research evaluating healthcare services needs to give attention to the role and position of rehabilitation services within current and future healthcare services.

Conclusion:

This work has contributed to understanding allied healthcare professionals' perspectives of contemporary practice. In addition, by focusing primarily on allied health professionals, this work gives voice to an often overlooked section of the healthcare workforce. The aims of the research were to provide detailed, contextually bound accounts of individuals' perceptions of their roles and working practices. Through the adoption of an ethnographic extended case-based methodology these aims have been addressed.

As opposed to professional identity, roles and boundaries being singular, defined only through the enactment of profession specific concepts or structured via the context in which individuals work, they are an ongoing product of negotiation, and integration of multiple meaning frames. The extent to which individuals extended their conceptualisation of practice (their roles and identities) appeared to be dependent on the scope for mediation, and to a lesser extent evidence of professional maturity. Recognition of these subtle interactions is central to the interpretation and understanding of contemporary professional practice and identity.

Professional roles, boundaries and identities are the product of active negotiations. Of significance is the assertion that these negotiations can only occur in the presence of shared values. The existence of a shared, normative element of healthcare professional practice was evidenced across all four case studies by a clear commitment by the respondents to risk reduction. This challenges the proposal that public sector professionals have lost a sense of meaning or purpose in their work.

Recognition of a normative element of healthcare professional practice rooted in biomedical principles provides an explanation as to why allied health professionals were able to sanction a lack of rehabilitation in their work. This interpretation brings into question the expansion of healthcare practice to accommodate more socially orientated paradigms of health care and as part of this, the drive for patients to take more responsibility for their own care. Building on the last point, the perceived lack of rehabilitation across the four case studies serves to highlight an apparent short-termism in the orientation of healthcare services.

Implications for practice:

This research adds to the growing evidence which indicates that in order to promote inter-professional team work and patient centred practice there needs to be clarity of patient need and focus of service provision. The absence of these two factors contributes to inter-professional rivalries. This transparency needs to be taken into account by managers and policy makers in the development of services within the new NHS. Two implications arise from this: Firstly, in order for professionals to focus on patient need, attention needs to be given to the common elements of the work of

healthcare professionals. Focusing on what is shared between professions during pre-registration education as well as in the work place will serve to facilitate this. It is acknowledged, however, that previous attempts to accomplish this appear to have faltered (Lewy, 2010). What this research has shown is that addressing this complex issue in a unidirectional approach is unlikely to be effective. Due to its complexity, more attention needs to be directed toward the clinical as opposed to the classroom setting. The second implication of the data is that professions either are part of, or fit into, services. In order to promote patient centred practice individual professionals must become part of services. Managers and educators therefore need to facilitate the development of service orientated as opposed to profession orientated healthcare professionals.

Finally, the recognition and sanctioning of a lack of rehabilitation by allied health professionals raises two questions. Firstly, what role if any should allied health professionals have in promoting and delivering ongoing rehabilitation? The second question centres on the currency of rehabilitation in the current NHS. This latter concern is brought to the fore when considered in relation to the current and predicted challenges facing healthcare providers and commissioners with regards to the growing elderly population and clients with long term conditions.

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Appendix A

Analytical process:

A detailed illustration of the analytical process for case study one has been provided as an example of the analysis used for all four case studies.

As described in the methodology, the analysis consisted of five iterative stages. The analysis involved a number of processes which transformed the data from its “raw” form to various stages of being “cooked” (LeCompte and Schensul, 1999, p. 3). It is important to underline the fact that these processes reflect but do not correspond to the five stages described in the methodology.

Section one illustrates the use of Nvivo

Section two contains copies of interview transcripts with annotations

Section three contains extracts from my research diary

Section four contains examples of how data was used in the creation of the poly-narrative for the case

Section five contains an example of the integration of theoretical interpretations with the case reports.

Section One

Section one illustrates the use of Nvivo during the analytical process. NVivo was used in the initial stage of analysis in order to break the data generated from observations and interviews into workable units. The cataloguing of the data at this stage was broad. For the first case study the data was managed by separating codes out into two general types, loosely reflecting the research questions and underlying propositions and theoretical assumptions. As the analytical processes progressed NVivo facilitated data management through acting as both a repository and a tool for manipulating the data.

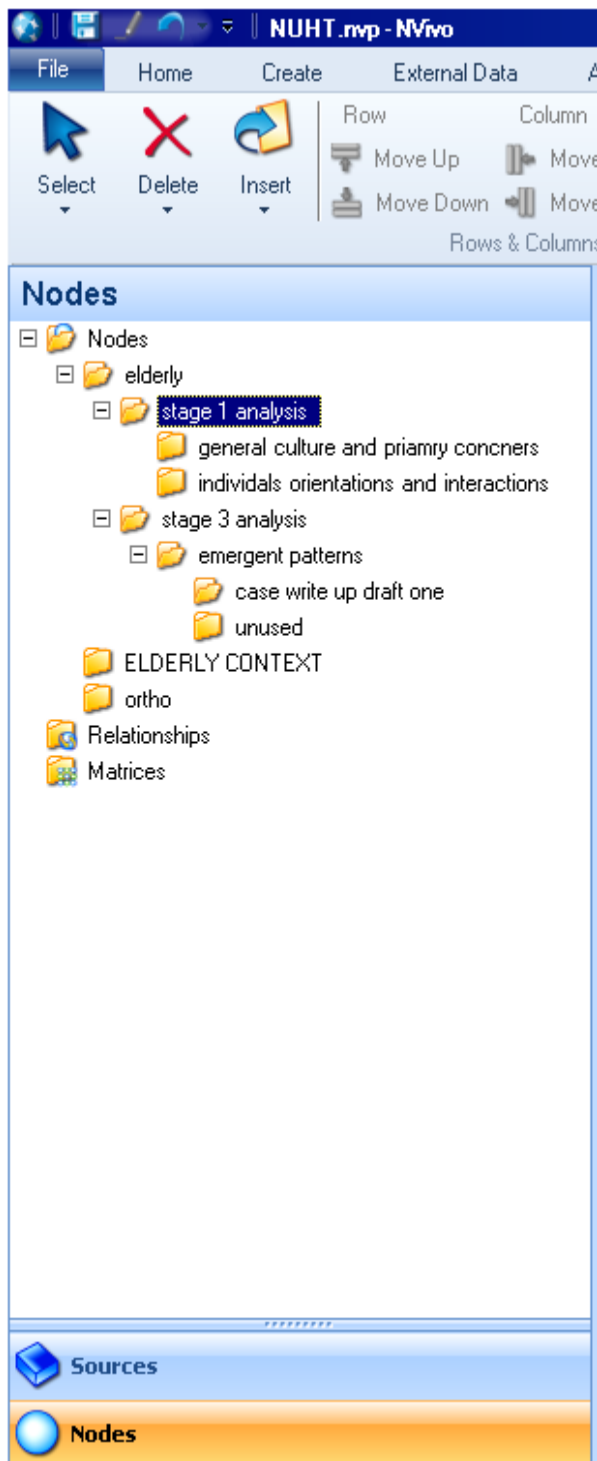
Included in this section are:

An example of how data was stored in NVivo

A list of all the codes generated during the initial analysis

An example of how codes were used to form categories and themes

An example illustrating how NVivo facilitated the construction of the case report



This extract from Nvivo illustrates the organisation of data at its most superficial level as well as the stages of data analysis.

During the first stage of analysis two very broad categories emerged these were culture and primary concerns and individuals orientations and interactions

Name
current manager is not rehab based
environment and rehabilitation
fear of litigation
getting the balance right
hospital setting is focused on safety as opposed to rehabilitation
in the hospital setting it comes down to facilitating a safe discharge
it comes down to discharge safe minimise risk
it does not seem like it is promoting health or healthy living
it is just absolute boredom
it is really heart breaking to see someone tethered to an alarm
it is supposed to be rehab but they don't get it
its a safety thing
its called a rehab ward but I don't really think its a rehab ward
its looking at the priorities of the acute service
medical vs rehab hospitals are expensive
medically stable dose not mean he can cope
more scope for rehab out of the acute wards
nurses role in rehab
nursing staff view of OT role
once they are medically fit they don't like to keep them in hospital so
organisational values

patients acceptance of the culture
patients in rehabilitation ward are unwell
professional value vs organisation
rehabilitation in secondary care
report writing to facilitate discharge
safety vs rehab
system shaping role
the medical team want the patient to go home as soon as they are medically stable
the nurses put a bedpan under his bum 5 times a night so we have not got there yet
the services are there in the community
the services are there in the community,
the whole concept is in and out
there is an idea of a rehab ward
therapists important in a rehab ward
things have changed in the past 10 years no not rehab focused
we are not getting them back to where they were before we are getting them just there
we are trying to improve function
we don't actually mention discharge until the patient is stable
we don't have time to assess for rehab goals
we don't push them beyond their baseline if they are safe

we have gone backwards
we have got, we cover two rehab wards, well they are called rehab wards,
we often spend our time facilitating discharges as opposed to carrying out rehab, yes
We're not doing anything now for the patients the Dr says, right home tomorrow.
what seems to happen is that people are deteriorating
you need to know the system
all patients referred to PT but not to OT
complexity of discharge
expectations of medicine
generic therapist
getting a second opinion
I put a recommendation in to the consultants
I'm fascinated by the stories that older people have to tell you know and the age that we see them they have very well formed personalities
I'm not an Ot all the time if I'm out at the weekend or if I'm at home I definitely can, I can cut from that,
its against everything that I, quality of life is important and that's what everybody seems to be losing more than when they went in and its
management as part of the lead physio's role
managing work load
medical vs rehab hospitals = infections
negotiation for more rehab physios with the drs

negotiation physio medics
not all referrals are appropriate
nurses are in control
nurses role here is different
Nurses view OT role as DC planning
often the doctors really don't know whether or not that patient would be appropriate for OT
OT's determining their role
pcp for successful discharge
Physio aligned with medicine
Physio and OT are completely different
physio is more, the assessment is more detailed than what we do, er, so what do I say
Physios are not permanent members of the team
Physio's don't discharge until the patient leaves the hospital
physios focus on function
Physio's views of OT as DC planning in elderly setting
physiotherapy and mental health
Physiotherapy is not only walking
professionalism, psychology of self-fulfilment
Profession's perspective of practice
protection of physio role
role of OT

running the show
safety as a means for other disciplines to influence discharge
sister feels she is in charge
so far touch wood they (drs) are ok with me
so we actually are at the centre of looking after the patient, then we use other disciplines in achieving our goals
then the physiotherapists their assessment is different from ours, well we used to have like, I wouldn't say problems
there have been a couple of times when the physios have had to do a home visit but it is rare
they normally take our point of view on board
ward staff make referrals to OT under direction of the medics
we are all in charge of the patients
we do have a physio nurse thing
we screen all our referrals we have to be careful
We, is always profession specific
Well it's the patients, its nothing else, I have problems with the nurses and other physios and all that, its just the patients I love.
working within scope of practice
I would like to be able to get away from this discharge, this rapid discharge facilitation of discharge
you have to really understand their perspective

Name	Sources	References	Created On	Created By	Modified On	Modified By
control over work	0	0	13/03/2012 16:37	GC	28/05/2012 16:27	GC
all patients referred to PT but not expectations of medicine	1	1	12/03/2014 14:02	GC	12/03/2014 13:54	GC
getting a second opinion	1	1	12/03/2014 14:02	GC	12/03/2014 13:58	GC
I put a recommendation in to the c	1	1	12/03/2014 14:02	GC	12/03/2014 13:55	GC
managing work load	1	1	12/03/2014 14:02	GC	11/03/2014 17:08	GC
negotiation physio medics	1	1	12/03/2014 14:02	GC	12/03/2014 13:57	GC
lack of understanding of reh	1	1	12/03/2014 14:02	GC	11/03/2014 16:35	GC
medical diagnosis	1	3	12/03/2014 14:02	GC	11/03/2014 17:09	GC
working outside of scope	1	1	12/03/2014 14:02	GC	11/03/2014 16:34	GC
not all referrals are appropriate	1	1	12/03/2014 14:02	GC	12/03/2014 13:54	GC
nurses are in control	1	1	12/03/2014 14:02	GC	12/03/2014 13:57	GC
Nurses view OT role as DC plan	1	1	12/03/2014 14:02	GC	28/05/2012 13:53	GC
OT's determining their role	1	2	12/03/2014 14:02	GC	12/03/2014 13:56	GC
Physio's don't discharge until th	1	1	12/03/2014 14:02	GC	11/03/2014 16:58	GC
running the show	1	1	12/03/2014 14:02	GC	12/03/2014 13:57	GC
sister feels she is in charge	2	2	12/03/2014 14:02	GC	11/03/2014 16:58	GC
so far touch wood they (dis) are	1	1	12/03/2014 14:02	GC	12/03/2014 13:48	GC
so we actually are at the centre	2	3	12/03/2014 14:02	GC	11/03/2014 16:58	GC
so we actually are at the centre	2	3	12/03/2014 14:02	GC	11/03/2014 16:58	GC
they normally take our point of	1	2	12/03/2014 14:02	GC	12/03/2014 13:54	GC
ward staff make referrals to OT u	4	4	12/03/2014 14:02	GC	11/03/2014 16:58	GC
dominance of medicine	1	3	12/03/2014 14:02	GC	11/03/2014 16:59	GC
we are all in charge of the pate	1	1	12/03/2014 14:02	GC	11/03/2014 17:04	GC
we score all our referrals we shv	1	2	12/03/2014 14:02	GC	11/03/2014 17:05	GC
working within scope of practice	1	1	12/03/2014 14:02	GC	11/03/2014 17:02	GC
Profession's perspective of practice	2	3	05/03/2012 14:03	GC	12/03/2014 13:44	GC
rehab vs care	0	0	12/03/2014 13:41	GC	12/03/2014 13:41	GC
safe discharge	0	0	13/03/2012 16:36	GC	11/03/2014 17:00	GC

This extract from Nvivo illustrates the development of categories and themes from the initial codes identified. Corresponding with the third analytical stage NVivo facilitated the manipulation and modelling of the data allowing for comparisons and contrasts to be made.

Nodes

- Nodes
 - elderly
 - stage 1: analysis
 - general culture and concerns
 - individuals orientations and interactions
 - stage 2: analysis
 - emergent patients
 - case write up draft one
 - unused
 - ELDERLY CONTEXT
 - ortho
 - Relationships
 - Matrices

case write up draft one

Name	Sources	References	Created On	Created By	Modified On	Modified By
control over work	1	1	05/03/2013 11:37	GC	05/03/2013 11:37	GC
safety as a means	1	1	19/03/2013 10:21	GC	19/03/2013 10:21	GC
The patient is rem	1	1	25/05/2012 15:03	GC	19/03/2013 10:30	GC
working in a hospi	1	3	13/03/2012 16:36	GC	19/03/2013 10:21	GC
process and focus of r	2	3	04/03/2013 16:59	GC	05/03/2013 16:23	GC
Professional perspecti	0	0	11/03/2014 10:44	GC	12/03/2014 14:46	GC
rehab vs care	1	1	05/03/2013 11:29	GC	12/03/2014 14:46	GC

GC 39 items

This extract from Nvivo illustrates how the software was used to facilitate the construction of the case report. In the fourth analytical stage the emergent categories and themes were grouped in order to structure the polynarrative

Section two

Section two contains copies of interview transcripts with annotations. Corresponding primarily to the second analytical stage described in the methodology coding of the data was performed without the use of NVivo. Although coding in NVivo facilitated data management, as a researcher I felt removed from the data in some way. In order to mediate against this I revisited the transcripts in full and coded by hand. These codes were then cross referenced with the initial analysis in stage one and where needed changes were made. Copies of the transcripts and the codes were sent to the two project supervisors for comments.

Three interviews have been included in this section. The first interview is from the band seven occupational therapist, the second is from the band seven Physiotherapists and the third is from the ward Sister

OT elder 1

Ok erm, I am really interested to hear what you do

Ok, do in this setting here

Yes

Ok, well er so we have got a care of the elderly Ot team which consists of myself a locum band 7 a band 6 and a band 5, and we should have another member of staff but its not filled at the moment,

And you are a, band 6?

Band 7 locum,

You're the band 7 locum, right

Yes so I am essentially responsible for the wait list, the referral wait list, erm, and we have got, we cover two rehab wards, well they are called rehab wards, and an acute ward but also acute care of the elderly outliers and yes so we try and facilitate, I guess our acute role here is to facilitate a safe discharge for the patients on our referral list, and erm yes that's what it probably comes down to.

You said rehab ward but you raised your eye brows

Oh yes, well its just that erm, we don't really have the, the staff capacity nor the time to erm, assess for rehab goals and to put a treatment plan in place, erm, often erm the patients who are on the rehab wards aren't actually appropriate for rehab in the first place because they're being sent there as a, to wait for their, to wait for a nursing home placement or to wait for a transfer to another hospital or something, so its really just another use of a bed er, and then often there is, yes so people who don't really have a rehab agenda, erm people who would benefit from rehab, erm, its often the case that they because of the pressure for beds that their rehab would be cut short and it would probably continue in the community so yes it really comes down to erm, discharge planning, effective discharge planning, and very quickly because of the staff capacity we often spend our time facilitating discharges as opposed to carrying out rehab, yes

Ok,

Yes, because discharge, discharge planning is very complex and very involved and takes up a lot of time so the time that is used, er, is used in facilitating a discharge is time away from rehab I guess so, yes, that's true. I feel as though I am being interviewed, I am! (Laughs)

You are being interviewed, but its ok. Is facilitating a discharge part of being an Ot or would you

Yes, well in this setting it is, in this acute setting it is, erm facilitating a safe discharge, but there is this idea of this rehab ward and so often we get a referral for a patient who is going home in the next or there is a discharge set for planned for the next couple of days and so between the time of referral and the time they go home there is absolutely no rehab that goes on in that time because the discharge planning takes up all of that time, er, so yes it ends up being, in an acute setting facilitating a safe discharge, umm, and with referral onto service which can carry out the rehab in the patient's own home or where ever it may be, so, yes,

Comment [gc1]: The Ot is seen as separate, this is consistent with the other professions i.e. nursing and Physio, when the respondents talk about teams they always start by saying the profession specific team (see also PT elder 1, (not PT elderly 3), PT elderly 2 and OT...7)

Comment [gc2]: context

Comment [gc3]: lists, management, organisation

Comment [gc4]: speaks volumes, firstly rehab seen as not being rehab in these settings (in the opinion of the OT), second, that acute OT is different from rehab, note this is also echoed by the nursing staff and the Physios, the priorities are different between acute care and rehabilitation, although in the eyes of the OT the organisation still does not provide rehabilitation, this is in contrast to the physios and the nurse who feel that they are providing rehabilitation, although in saying this the concept does differ between the two professions

Comment [gc5]: structure shaping the role of the Ot, time, staff (are these structural issues, what do I mean by structure?, no I am not sure that I do, it is the organisation of work, this is not how sociology defines structure - social structures determine action, but what is resource allocation and work load if not social structure, structural factors determining social action. This needs further clarification and discussion, but what is apparent is that factors out of the control of the OT go into shaping what she does. Note the structure action debate (Giddens)

Comment [gc6]: As defined by who, this is interesting when compared to both Physio and Nursing staff, the concept of rehab seems to differ between the professions and appears to be (as exemplified by PT elderly 3) shaped by the organisation to a degree, these organisational priorities appear to be accepted more by the Nurses and the Physios and less by the OTs, why is this (one possible explanation could lie in the culture/frames of reference of the ... [1])

Comment [gc7]: Primary role of the OT?

Comment [gc8]: Is this a justification from a professional point of view? Also there is the acknowledgement that the priority of the organisation takes time away from other tasks i.e. rehabilitation

Comment [gc9]: An idea of a rehab ward, not her idea but an idea the question is who's. There is also evidence here that context shapes role, i.e. in this setting the priority is a safe discharge, but you get the impression that in other settings this ... [2]

Comment [gc10]: It is not that rehab is not needed it is just not in this setting

Novio

Is that because the patients don't spend very long on the ward?

Er, they either don't spend that much time on the ward because there is the pressures for beds for the new acute patients coming down from the medical wards or [redacted] ward erm, either that they are not spending enough time there or they become medically fit, once they are medically fit they don't like to keep them in hospital so, that would be the best time for rehab but they see that as oh well they are medically fit they need to get out, which is I guess fair enough being in such an environment where they are I guess prone to infection from other people, because there are still people who are medically unwell on those wards as well, so there is that, and then, oh gosh I have lost my track, what was the question again (laughs)

Medicine is rehab
up to hospital

I was just wondering why you kind of said you got a referral but then they are going home in two days, is that because there is such a rapid turn over

System shaping role

Oh yes, ok sure rapid turn over or that we don't get the referral until it is too late, erm because its not a blanket referral system er, we do get quite a lot of inappropriate referrals and time spent screening and attending to all the documentation required to, when you do receive a referral is again I guess time that is wasted that could be used in, more effectively with the patients that we actually have on our list and are appropriate for our service at the time, so that's is something that we are struggling with at the moment and I think it has been like that for a while as well, big turnover of staff, so yes, erm, identifying, I guess we're looking at, well its this idea of educating staff regarding the role, our role, and when to refer and who to refer who not to refer, but that is something that doesn't carry over from staff member to staff member and there are lots of agency staff as well so.

Lack of understanding of OT

So who makes the referrals?

Its really, well at the end of the day it's the ward staff but that can be under the direction of the doctors and often the doctors really don't know whether or not that patient would be appropriate for OT as well so there is educating, education comes down to not just the nursing staff and the health care assistants and, its also the doctors as well so, yes, it's a rat, but then as soon you know we have to be quite erm, we have to screen, we have to screen our referrals therefore, erm because as soon as we agree to take a referral on or to accept it then we have our duty of care to make sure we carry out a through comprehensive assessment, so, we need to be very careful about who we are accepting and who we are not and making sure that they meet the criteria, and that criteria were are still not, its literally not written down as a formal criteria but it is something that we're, its looking at the priorities for the acute service, so patients who are most vulnerable who live alone who are needing help but don't have any help, they would be like our main priority, patients who are going back to a residential home or a nursing home they would be very low priority so, yes, but if someone is referred to us and they er, are independent with all of their ADLs on the ward and there are no voiced concerns from the patient or a relative then we would be questioning then why, why is this referral being made to us and if it is an issue regarding major adaptations the we would not accept the referral and would refer on to the community, so, I think I am talking abit too much (laughs)

Setting the bar right

OTs struggling their role

Too close to pick up

No, no, its an interview that's what you do

also is this is this notion of duty of care to the pt OT long complex process?

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Comment [gc11]: Two, possibly conflicting influences (one organisational, one institutional) which affect how the OT works

Comment [gc12]: The assumption being that they is the medical profession

Comment [gc13]: The Ot seems to feel that there is a place for rehab in the acute setting, but can justify it from a medical perspective, but there appears to be a sense of conflict here, the patients would benefit but they are at risk (note this notion of risk and rehab come up in PT elder 3 also), here is an example of the more powerful discourse (i.e. medicine) coming through, shaping the OT's views (see Foucault)

Comment [gc14]: For what? Rehab?

Comment [gc15]: Time spent screening patient for the service takes away time from those patient already on the books/receiving treatment, "all the paper work" the degree of bureaucracy, but who implemented this? A possible control mechanism employed by the OTs to help determine who they see and when, but also maintain an aspect of their concept of rehab, but the pressures and needs of the organisation actualised by the dominant institutions restrict this level of control so that in the end all the OTs feel they are doing is facilitating discharge

Comment [gc16]: What is OT?, What is OT in the acute setting, with this client group?, it seems to be poorly defined (see pilot interview OT manager) and understood?

Comment [gc17]: Dominant institutions, (medicine and nursing staff, i.e. the ward staff), also here is the hierarchy within the organisation amongst the health professions (an issue again which is evident from a number of the respondents)

Comment [gc18]: Process (initially) acceptance of a referral generates work, a through assessment is carried out. Reading down it would appear that the OTs take a referral and then screen the patient (don't trust the opinion of the referring professional? why? because they don't understand the role of OT).

The issues of being careful is interesting, almost as if they are letting the patient into some kind of club, or that the OTs are custodians of certain resources or privileged which only certain individ ... [3]

Comment [gc19]: Criteria, no one knows is this an issue of measureability (or lack of?)

Comment [gc20]: The criteria for rehab are those patients who may have a delayed discharge?! There seems to be a real issue here, the OTs don't have space for rehab because of the pressure put upon them by the ... [4]

Arr right, does that sound all right?

Yes, yes that sounds fine. You mentioned part of what you do, you have to educate members of staff about the role of OT, so what is the role of OT?

Ok so the role in this setting and on these wards that we are dealing with within the resources that we have available, the role is to, for the patients that are referred to us to carry out an assessment of their functional social cognitive needs and erm, looking at what, what you know comparing at what their needs are now to what their baseline needs are, making a comparison looking at the gap and then establishing well is that erm, can we put things in place like equipment or care packages or access, increase the access to services to help fill that gap and make sure their needs are met, to facilitate a safe discharge from hospital and then I, acknowledging that more longer term needs are addressed by the community services, so we are really looking at the acute need and then referring on to make sure a continuum of care as appropriate so, yes, that's the role

Ok, and you said in this setting, is that because its quite specific

That's right yes, so, yes very specific to different fields so in the hospital setting its often erm, you know amongst all the teams it, it really comes down to facilitating a safe discharge and timely discharge from hospital erm, in the community the focus would be, well you'd have the patients would, could possibly stay on your case loads for a lot longer er, and they would be looking at different, different aspects to their quality of life, so this is essentially looking at how to get someone out of hospital, safely and then yes, so, oh gosh I'm talking all over the place I can't figure out where I am going (laughs)

Its ok, you mentioned about when you screen patients and you have criteria but those criteria aren't explicit

Yes I think that erm, for, its kind of, it, it is amongst the OTs but not for the people who are referring so what at the moment, this is what I think we need to establish and we need to have like we have got in other places I have worked in, there is a referral criteria, an OT referral criteria which is pinned up on every ward and there is education around that, there is a session with the ward manager and that is filtered down through the other staff, when they refer the patient they actually have to go through the screening criteria by an admin staff or an Ot, before that referral is accepted, so that referral is screened on the spot as it is being made and so er, it can be challenged as to why, why, why they are referring, if it doesn't seem to be appropriate they can explain why, and make a note of where, you know what needs to be done instead, maybe it's a referral to social worker as opposed to an OT, so then we have more controlled over the referrals coming in and erm, and help, hopefully having a, I think streamlining the referral, the referral process, but in this place, the referrals come through via the [redacted] and we have no erm there is no screening process in that it is something that they do online, sorry on the system and er, and that's that, so then we have to, we're in a position now that well, we should, discovering that we have all these referrals you know like 15 overnight, you know there is only 2 or 3 of us then its well ok lets go through and try and prioritise, after time you establish that a lot of these referrals aren't appropriate in the slightest so then I feel like, we feel that we need to come up with a bit of a screen which we do we do screen but it needs to be more formal I think but for us, ourselves we look at, well yes, how is the patient functioning on the ward, are they mobilising independently with or without aid, are they

working this or redefine role ++
exaggerated in the roles + of dominance

system shapes role of OT

rehab in 24 hrs

OTs determine their role

control over work

OT in 24 hrs core

SA

Comment [gc21]: Context determining role (there my question has been answered can I go home now!!)

Comment [gc22]: Explanation of the role of acute OT. Assess at a number of levels (note non of which are medical – cross reference with the nursing professions concept of rehabilitation looking at the social needs of the patient, a more holistic perspective on patient care – why does this not fit into the acute setting? Umm I wonder. Well moving away from the sarcasm for a moment, placed into the context of all the data there is a real shift here from what the nurses and the medics present as the priority and to some degree what the Physios feel is the priority to a more non-medicalised view of the patient

Interpretations
Culture
Dominant discourse (this being an example of the effects of this)
Intra-professional boundaries (see the lit re this)

Comment [gc23]: The focus of rehab in the acute setting – this is the nub of the narrative, the needs of the organisation (as reinforced by the dominant institutions) vs the concept of rehab from an OT perspective which has its roots in community based/long term care (assumption will need to check this)

Comment [gc24]: Making professional practice explicit, why is it not clear to all? Dominance of the medical discourse? Lack of clarity within OT (no... there is commonality here)
A protective/control mechanism (there is also evidence to support this)
Just poor organisation (there is evidence to support this)

Comment [gc25]: Is this about control?, being able to challenge the decisions of others, decisions about what the OT does, is it that she is talking about putting mechanisms in place that give her more control over what she does, make the work more relevant to OT, is this an example of the professional project? The semi profession attempting to delineate the boundaries of her profession by putting in place bureaucratic mechanisms to control content of work- trying to make it more OT

Comment [gc26]: The system does not support their work, what they do their role....

SA

transferring independently with or without equipment, er, are they needing assistance with their personal cares, how much assistance erm, do they consent to having an Ot do they want to participate in an assessment do they want to have help at home even if they may be having help on the ward, and they say they are needing help on the ward but they don't want any help at home do we get involved just because they are needing help on the ward but they don't want it at home, does that justify us seeing them you know it is all these questions so, screening them in order to identify whether they are appropriate for our service or whether its more appropriate for the community services or whether they are appropriate for OT at all, yes,

OT in 24/7 cde

Ok, do you enjoy what you do?

Yes, erm, I do but I would like to be able to er, I would like to be able to get away from this discharge, this rapid discharge facilitation of discharge, I would like to be able to have the opportunity to get to know your patient, get to know, you know you can't build up a rapport with them after one assessment you need time, to, to establish a, erm, a therapeutic relationship with a patient in order to really to set, to set meaningful goals, and then, I don't feel that we can do that in this setting erm, so I would prefer to have more time to do that but we don't have that so, yes, but otherwise I do really enjoy working with older people, I always have worked with older people and I can't really seem to pull myself away from that so, so yes, its just it would be nice to have a little bit more time to, to see actually and also see the benefits of your inputs as well erm, so yes,

Professional I

Why do you like working with older people?

Erm, I don't know I think that when I was going through Uni I erm, thought that would be the last, the last area or field I would choose to work in, then I was erm given a placement in rehab of the older person and I was, erm, dreading it apparently it was the last, the last one available and I got that and I was dreading it but then after I found the experience really enjoyable, I just, that was it I just thought that was the area I want to work in, erm, and I guess I, I'm fascinated by the stories that older people have to tell you know and the age that we see them they have very well formed personalities and some interesting stories to tell, and also there is a multitude of, of illness and disabilities that affect that person, so erm, I don't know its, it's a fascinating area to be working in and I, I yes, I do, I like the one on one contact, that's what I prefer as opposed to more of a management role I prefer the one on one so, yes ummm

Professional I

to 1 place

Ok erm, as an Ot working in elderly, do you work with other professionals?

Yes, so we work with other member so the multi-disciplinary team so we work with Physiotherapists very closely, with nursing staff health care assistants erm even the ward clerks, the doctors, the consultants are very, very present on the wards, especially here I seem quite a lot and they attend the meetings which is great erm, and social workers we, we do work with closely and then yes and other professionals in the community as well, and then there is also erm agencies like services, more voluntary services as well erm both health and social care services, yes a mixture

OT in 24/7 cde

Can you give me an example

Oh of

Of working with other professionals

Comment [gc27]: Again there is agreement amongst the OTs as to what their role is and constitutes the OT role, however, again there is this emphasis on assessment, what is interesting here also is the hint at patient focused care, do they want OT, seen as optional contrast to say nursing, is this optional also?

Comment [gc28]: Having time with the patient is seen as really important, but the system, or the ethos of the organisation does not facilitate this. As a concept this is more therapy as opposed to medical (see data from the observations) may be? Also physios did not see this as an issue why not?

S/A Dred Rep

Maybe because of how they operate within the system, they don't have a delay before they see patients, everybody needs physio...and therefore even though the patients are not around for long the physios still get to see them.

The question is then why is it the OT's don't just see everyone - does everyone need OT? No apparently not, it is almost (as indicated above) that OT is an add on optional not seen as essential....?

new 2/1

Comment [gc29]: Psychology of self, individual reward of seeing the results of your efforts...see umm can not find the paper

Pp2

Comment [gc30]: The patients make the work interesting, both them as individuals and their needs from a professional perspective. Is this the link between professional and personal identity, they dynamic relationship between the two forming the concept of professionalism...?

Pp2

Oh ok, so like a physio?

You choose

role
overlap

Ok say with the physio often erm, we'd ask either the OT or the Physio would ask to do a joint assessment erm joint sort of functional mobility assessment, erm it might be because that patient is needing assistance quite a lot of assistance to, to, erm complete transfers and it's a good opportunity for both professions to see what level that patients at and also it avoids doubling up of, I guess it avoids the patient being harassed by the same profession, I mean by, by or to do the same thing by different professionals, especially when often they are may be, may be not feeling the greatest and they may not be quite not be medically fit yet. Yes so joint assessments and erm, erm what else I guess looking at umm there have been a couple of times that it has been appropriate for the physio to attend a home visit, that hasn't been, that hasn't happened recently though, it just depends on the situation, erm, erm, but it has happened and erm, I guess bouncing ideas of us to I guess trying to facilitate a safe discharge and looking at well say we have gone to do a visit the patient's place, the patient is now needing a new aid say a rotator frame, before was using a stick, so patient says on I'm not sure if that's going to fit through my house, so we'll go out and have a look see if that is the case, erm if its not going to fit and its not possible to rearrange furniture its not possible to remove furniture erm its not possible for them to be re-housed then erm I'd perhaps come back to the physio and say well how realistic is it for this patient to walk with a stick again before they, they go home and can, can they be assessed again whilst they are in hospital, so things, things like that, that's an example.

central
over
work

Comment [gc31]: It seems that when ever examples are given they are joint assessments, not joint treatments. *MT*

Again also here the example from practice given by the Ot is an assessment

Comment [gc32]: Indicates a degree of role overlap with regards to assessment anyway... *Q10*

Comment [gc33]: Tag on to 32

Comment [gc34]: Again the focus of the intervention is to facilitate a safe discharge!!! *DIC*

Ok, you mentioned that if you were looking at transfers and you know with the physio, and to save the patient having to do the same thing with different professions

OT
uses of
physio

Oh right yes, I guess, it depends erm erm, often it has been in the past it might be that the physio has come in to do, as they do with all their patients, they go and get them up and go for their treatment session and then the OTs needing to establish that, the same well, we need to establish what their transfer ability is like and their mobility, erm so, we would then go in and do the assessment as well, and especially when we have only got a couple of days to do this, it would often be the case that we would be asking the patient to do the same thing at the same time or moments between, and erm there have been times in the past where the patients get really tired quickly therefore the performance that we see is not their greatest erm, they're still, may be because they are de-conditioned they are still recovering, they get really grumpy with you they have just had, they have just been bothered (laughs), this is an example its not always like this, so yes so a joint assessment erm I guess also, it would be good if it could happen, it could work out so that we could do that all the time but its just that we don't often see all the patients where as physios often do, getting a timetable together would be a bit awkward, but keeping the communication lines open it can be done ad hoc so that's good, erm, I guess its, I guess its two heads together you know at the same time your idea, my idea of someone being independent vers physios idea of them being, I think its getting more of an idea well you have got two perspectives and is it well yes, is it something like joint goals can be made, is it easier for the patient to work with two people together or two professionals quite separately, that's really confusing sorry! (laughs)

role
overlap

system
overlap
role

role
overlap

MT
Comment [gc35]: Patient need determining the focus of the intervention? Or is there a degree of pragmatism here the situation not just medical factors influencing the decisions regarding treatment

Q10
Comment [gc36]: Role over lap, it appears that what would be part of the physio's treatment is part of the Ot's assessment, different focus, same task

Comment [gc37]: this is confirmed by the data from the physio's *SA*

No its ok, its ok, I am just thinking do they do the perspectives of the professions differ that much?

role overlap

May be, no I guess it, I mean defiantly I will say it has been noted in the past that, I guess the level of assistance, like what I would call minimum assistance compared to moderate assistance compared to maximum assistance, defiantly between Ot and physio but also more between OT and, OT physio as one and nursing staff, so this idea of how much is minimum moderate and maximum, especially I think, its important for us especially when we are looking at making recommendations for care packages and manual handling, erm standards, er,

Could you give me an example, would nursing staff think a person is more independent than a physio or OT or is it the other way around?

It can be both, yes visa vesa,

But there is a difference?

Yes, that's why kind of, you'd want to just cover the tracks by, by asking a few more questions about well, what does that involve, what is minimal assistance does that mean er, say ok lets give an example, so erm, nursing staff saying oh yep they need assistance with washing and dressing ok, and we would be like ok is that assistance of one person or is it assistance of two people, oh yes assistance of one, is that quite a lot assistance are you getting, are you using quite a lot of your energy, or erm, is it just a little bit, a little bit of fine prompting or physical cueing or is setup, is just setting up the environment, set up assistance with out any physical contact or, is it verbal prompting or yes, just really kind of establishing how much hands on assistance is required or, is it something that you need, you need to assist the patient in initiating and then they can then complete it so, erm, I think these, again this is all really important for us to identify when we are setting goals and I guess care plans in the community as to how much assistance the carer will have to provide erm, in order, while you would want to maximise the patients potential, so we don't want carers doing too much but then not enough, so we don't want to get that wrong, but that does change and therefore needs monitoring in the community erm, yes and of course with the manual handling policies as well they need to be clear about how many staff they need and what equipment they'll need so yes, is that alright?

Yes, erm, you mentioned that your primary role is to facilitate a safe discharge,

Yes, sure, yep (laughs)

Is that right, or is your primary role something else?

Yes, yes, no no no it is right and I did say that and I think that's yes you are right, that's really what it would come down to a discharge that is safe minimises risk erm, but maximises independence as much as possible within the time frame that we have working with people so,

Why is there a but there, because you say that your main role is to facilitate discharge, yes but...

Yes, or facilitate a safe, a safe discharge, yes its just erm,

You don't think that's what you should be doing or?

Comment [gc38]: the different professions have different interpretations of the same thing, i.e. the patients ability to perform a task, this is due maybe to the difference in frames of reference. This is also a wider issue when we look at the concept of rehabilitation in this setting, the different professions feel they are contributing to this concept to a greater or lesser degree depending on how they conceptualise it.

There are positive and negatives of these differing frames of reference, the positive is "two heads are better than one" (see above) the negative is the lack of understanding of roles and the potential overlap of activities which could have a negative impact on the patient. It is interesting also the mention of standards, standardisation, communicating the functional ability of the patient and the needs of that patient, depending on who you ask you may get a different answer!

Comment [gc39]: Difference between the professions, between nurses and OT's what the nurses may see as a physical task, washing and dressing, the OT's see as a developmental task, one which needs further delineation the outcome of which has implications for the patients current and future rehab needs, resource needs. Unpacking the box that is the nature of rehabilitation in secondary care, it is becoming apparent that it depends on who you ask, all professions are involved in rehabilitation but the focus and the very idea of what that means differs amongst the professions, this then leads to a lack of understanding, breakdown in communication and a questioning of roles and values (particularly in the case of OT). I guess a key question will be is this the same in the community and if not why not - my current thinking is that secondary care and it's delivery of rehab is shaped by the organisation (needs of the organisation to move patients through rapidly) and the dominant institutions, i.e. the dominant professions i.e. nursing and medicine it is apparent from the data (see physio also) that the AHP's are dependent on the actions of the nurses and the decisions ... [5]

Comment [gc40]: Getting the balance right between the needs of the organisation and the needs of the patient (is it the needs of the patient or the goals of the healthcare professional. Reduce the risk to the organisation and the patient, but increase the independence of the patient, the time limit being set by the medicals! (although this is open to negotiation, and this is what seems to be apparent from all the interviews (bar the nurses) that the key negotiating area for the AHPs is time to focus on their priority, i.e. rehab, this has been taken away from then by the medicals and is sanctioned by the organisation or visa versa...?

safe D/C

Setting the bar right

DC

Professional
buffer

No, I just think its something that really, it erm, it can often take the focus off the erm, person I think as well, erm yes it gets a blurry its like yes we're just focusing on making sure that this level of safety is maintained when really maybe, that level of safety might not be a priority might not be priority for that person or that's not something that they really care about as much as the, the wider, the trust cares about so you know, and erm, I think its this threat of what would happen if risk wasn't reduced or if erm, yes so I think we can all get a bit carried away with this whole idea of reducing risk and maximising safety and therefore maybe a patient could stay in hospital two weeks longer while something's get addressed, and its, in the meanwhile that person deteriorates or their wish to die at home is not facilitated at the end because there's this, its not safe or some, so erm yes it can be a bit sticky erm, because, really it kind of, yes it can take away it can move, it can, lets say erm, its like the shift can, yes there could be a shift from patient centred care if you are looking purely at safety on discharge, erm, I try and do both, so yes, and then I guess with the elderly you are looking at capacity issues as well so we often are involved quite closely with that and cognition and assessment, assessing cognition, functional cognition as well cognition in, during activity not just on a test so erm, yes, yes, don't know where I'm at now (laughs)

Comment [gc41]: The focus of the organisations vs the focus of the occupational therapist this again is indicating to a degree the frame of reference of OT

Prof W-C
in organisation

Comment [gc42]: Again the friction point between the organisation and the professional, it may be that the OT is acting as a buffer between the hospital and the patient, trying to get the balance between safety and rehab (rehabilitation is a risky business!) which is applied in an environment which aims to minimise risk, this balance can get a bit "sticky" and I would imagine can be quite emotive. Expand on this and compare to VW!

Comment [gc43]: Balance!

Getting the
balance right

Do you feel as if your, that the priorities are set for you?

Yes I do in a way with the safety on discharge yes, I do kind of feel that, I don't know how, or exactly how or why that, it just feels that that's the culture and it, well it is the culture so..and of course its important erm, because we're trying to erm maximise there safety therefore we don't want them coming back into hospital every two second, and they don't want to be coming back into hospital every two seconds, not everyone chooses to be in hospital so erm, but then I think its being clear, its being clear about just as long as someone knows so the patient knows or the family knows what the risks are and making that decision as to whether they choose to accept that level of risk then we should facilitate around that erm, but then if there is a re-admission then there's this erm, obviously then the case will be brought up again and they will review what happened last time and why did this happen, and, so its kind of, in many ways its kind of a bit paternalistic this idea of, I don't know, making, I think to enjoy life I think there has got to be some element of risk(laughs), risk taking, god, so anyway yes

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Comment [gc44]: The ethos or culture of the organisation, note again culture. Organisation shaping practice

S/A

Yes I'd buy into that philosophy

Yes, so ummm, umm,

Why, why, I kind of get the impression that that sits uncomfortably with you, I'm just intrigued as to why

Oh, sorry say that again

Does that sit uncomfortably with you the fact that

System
shaping
role

Errrr, not really, no not really, I think that you become so used to working in that, that mind set erm, and because every professional is geared towards that as in looking to that as a goal in this setting, erm, I guess, yes, yes, no it doesn't sit uncomfortably, I just think its, its just something that we'll promote and we'll promote because, not because just we have to but because that's erm a value, professional value, personal value but then I just think that sometimes there is, that there is too much emphasis on it

Comment [gc45]: The emphasis on safety is not an antipathy of professional practice/role and it is accepted that it is part of the climate or culture of the organisation, but...it is seen as a one size fits all, a doctrine which inhibits flexibility in the expression of other professional values

S/A

Is it a professional value and a personal value

Well yes, yes, but I'm not sure to what extent like, compared to other things and patient centred care I don't know you know if its not something, it's a balance its more of a balance, I feel that the hospital setting, working in a hospital setting the focus is more on safety, erm, as opposed to may be maximising independence and say quality of life you know because that's, may be something that the community teams can continue to do so, erm yes

But every professional you said is geared towards safety

It feels that way in the hospital yes for discharge its like..

Why, why

Well I think its erm well it just seems to be that erm, obviously, well I guess, there's the risks associated with, if someone is to go home to an unsafe environment erm, then whats the chances of re-admission for x or this and so we're trying to minimise those risks you know because its better for people to be in their own home as opposed to an institution where they can loose, at risk of losing erm independence so, erm, its it is it appears to be, it's a value (laughs) erm, its something that generates a, the discharge or this focus of safety and discharge erm, so, I mean if er if doctors were, well from a medical point of view they are medically fit but they do value our input and in our MDTs we have discussions about, well there's this patient, is this patient ready to go home, well there are these issues outstanding erm, some of them which may not be an issue for the patient erm, but yes, do so, and we often, we have, we come across you know, there is a team decision made as to whether well does discharge, do we wait until that environment is now safe or do we yes, I feel like I'm losing track (laughs) sorry

No you're not you're not I just want to you said, there is one thing I want to pick up on I just want to close this you just said, there is an issues there that it may not be an issue for the patient but its an issues for , kind of the professional

Yes

Can you give me an example?

Erm, so lets say oh gosh right, I'm trying to think of something recently erm, umm, lets say, well lets say maybe its to do with a level of a standard of hygiene say, like in the home erm, they might have rats in their home, or they might have got mice I think and then that's all of a sudden amongst the team if that's brought up at the team then that generates this whole, Oh, oh gosh well that's got to be sorted before that person goes home and Oh, that's something that, depending on what the situation is and where that person is coming from whether they have a congestive impairment that's making them vulnerable, but I thinks its just, lets just say that they've got capacity, there's not there's no cognitive impairment but they have mentioned that they've got mice but they, they don't feel that's an issue, you know a lot of places in [redacted] do, erm but then the team feel the social workers, well they need to have, they need to have that sorted before they go home that needs to be addressed before they go home, erm , I don't know if that's the best example actually

No that's a perfect example

Comment [gc46]: See above, it is about getting a balance and in the eyes of the Ot this balance is not there in the acute setting, but it would be in the community (check in VW).

S/A
around DIC

Comment [gc47]: It is as if the whole point of being in hospital is to get out of it, rehab is therefore geared to getting people out of hospital, this does not sit with the underlying philosophy or frame of reference of Ot and therefore we have this point of friction, the Ot can see that her role is facilitating a discharge is important, and acknowledges how it fits into the wider organisation, however, it prevents her from fulfilling her professional role (note not her organisational one) and there for she finds it sticky and one gets the impression a little frustrating

S/A

Comment [gc48]: Professionalization of a problem, paternalism,

Ah (laughs) is it, ok right!

No, no that's fine, I'm conscious of time, you mentioned that, er from a , you were talking about values , erm , and kind of like the value in this setting is the safe discharge and you mentioned kind of professionally and personally, and

To an extent yes

Ye, I just want to unpick a little bit is its ok this notion of professional value and personal value, and.

Umm, well I guess when you're at work its kind of inbuilt as one, yes its something that really, its engrained really so, erm, its just the way that we, we think, and I'm not sure whether its been all these years working in the hospital setting whether tats, that's changed the way I feel about it because that's just the way we work and get used to working get focused, be focused on whether you know when I graduated from university whether that was the focus I don't think it was, the focus was more, on facilitating erm patient centre care and client centred car, erm safety is a part of that, but it's the whole picture from my pint of view, but it is definitely something what I mean is that it is something that is valued, but I don't know whether it is something that should be the main emphasis of acute hospital care and discharges yes,

And is that a professional or is that a personal opinion, or are you saying that you, here you can't separate them?

Oh yes, no I think that's personal, that's personal, that about this emphasis on it erm, but it is, I mean it is something that the, OTs that OTs do do, that is their role, but its also a physio role its also its nursing role its doctors its social workers erm, and has that role been developed because of the policies that are in place and that we have to meet those policies somehow and it comes down to well this has to be met in order for this patient to be discharged, erm, yes, so, yes of course there's, value that but I just yes, I just want to make it clear that that's something that is important safety erm, but, yes I don't, I don't know if it should be the main focus, yes, umm, yes.

Ok, it's a difficult one to answer, that kind of separation from personal and professional, because they just don't, yes, I mean where do , where do you stop and you as an OT start?

Yes, that's true, yes, I think, well I think the longer you have been in a role then you then you, or a line or failed, you become very, you know, I think you kind of feel like, you know what the focus of the you know what the purpose of your job is, and you know, what, erm, its not like that you master it the longer, well you do I guess you start to master it the longer you go, you can't fully master it all because you've got daily challenges that are very different from the day before or the year before, erm, yes so I feel may be its, its engrained, that becomes stronger as you go through, maybe so much so where you might forget to stop and think, may be like this, Oh is this where we should be going? Or are we just getting carried away with the way it has been the way it is, erm, is this, is this the way it should be? Ummm, Because I think if we were to compare how it was, how it is now to what, all the theory and lovely models and philosophies that we had going through university I think it would be very different given that the resources that we get told about in university aren't actually there in reality! So yes, umm the barriers I guess as well, the pressure for discharge, erm, yes, that's it.

P Free it Ref
Comment [gc49]: Professional socialisation, contributed to by education, work place (organisation), role, (in that order). The clash between the ideals of education and the realities of the role?

Mismatch between theory and practice
This needs to be contextualised with regards to the changes that have gone on in the NHS also look at how the role in the VW is shaping professional identity
Note doe this Ot have an identity crisis?

SIA
Comment [gc50]: Policy and organisational values shaping professional role and values? Note a key theme is safety on discharge!!

Prof Free it Ref
Comment [gc51]: Professional socialisation, contributed to by education, work place (organisation), role, (in that order). The clash between the ideals of education and the realities of the role?

So when you are at work are you erm, I don't want to say your name for the tape, are you you or are you you the OT?

Erm, the OT

What's the difference?

Well, I guess, because I wouldn't be, I wouldn't be spending my time doing this if I wasn't really into it, if I didn't

If you weren't being an Ot

If I didn't resonate with it, yes, but then I'm not an Ot all the time if I'm out at the weekend of if I'm at home I definitely can, I can cut from that, I don't always think like that you know when I am out in the street I can see people who might be at risk you know, but I don't go up to them and give them the once over with an assessment or say oh you might want to go and see your local physio (laughs), so yes, but erm, I think because there's, well try and obtain an occupational balance, so erm, but yes, umm

Why don't you do it when you are out in the street?

Oh, I don't know, I guess, may be the focus is on something else like getting to the shop before it closes (laughs), erm, but yes, no I mean I'm just, I'm emphasising there, its not to say that I don't see it I definitely see it and pick it up but you know, how its, I don't think its my pace to do that, I don't know I haven't really figured that one out yet (laughs), imposing my values on

You're allowed to do it here

Well yes, I guess we have to make sure we have consent before we go ahead with any treatment, or an assessment takes place so yes. Oh gosh I'm wondering what this transcript is going to sound like and how many hours its going to take you beyond the 8 hours to transcribe (laughs)

It will be fine it will. Is there anything else you would like to add?

Ummm, I don't think so, no I don't think so, yes, does that sound like you've got what you need?

Yes, no its good, you're first person to kind of talk about kind of the personal and the professional, and I'm interested in that and its something I'm really struggling to get my head around, for me, where does me, where does ~~me~~ stop and where does ~~me~~ the physio start?

Yes, that's true, yes I don't know, yes, because its like yes, I don't necessarily have, well if we look at the philosophy of OT erm, I not necessarily engage in meaningful activity all the time, (laughs) out side, I don't balance, have a necessarily healthy occupational balance so, but erm, yes,

Ok I'll stop this then

Ok.

Professor 1.6 I

Page 1: [1] Comment [gc6]	graham8	10/01/2012 13:34:00
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As defined by who, this is interesting when compared to both Physio and Nursing staff, the concept of rehab seems to differ between the professions and appears to be (as exemplified by PT elderly 3) shaped by the organisation to a degree, these organisational priorities appear to be accepted more by the Nurses and the Physios and less by the OTs, why is this (one possible explanation could lie in the culture/frames of reference of the different professions, alternatively it could be an individual thing; I have to bear this in mind also)

Page 1: [2] Comment [gc9]	graham8	10/01/2012 14:33:00
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An idea of a rehab ward, not her idea but an idea the question is who's. There is also evidence here that context shapes role, i.e in this setting the priority is a safe discharge, but you get the impression that in other settings this would not be the case. In addition here is the further evidence of the structure shaping the activity, i.e. the referral comes in late therefore there is not time for rehab, why does the referral come in so late? This is a very interesting point which needs further expansion, when compared to physio where all patients are seen this issue of waiting for a referral does not occur, why then does it happen in OT?, evidence from the NS, the OTs and the Physios goes some way to providing a rationale for this ("everybody needs Physio", and due to the role of the nursing staff everybody needs nursing input). The acute nature of the patients conditions provide space for the other professions to operate, however, OT as a profession does not naturally (assumption on my part) occupy this space and although the wards are titled rehabilitation what is apparent from the data (both interviews and observations) is that once medically fit the patients are moved to discharge (the format of operation is determined by the patients medical status not by their rehab need), this is, however, at a superficial level, as what the data does reveal are numerous examples of where the AHPs try and negotiate this space for rehab, and it could be argued (see below, contribute to a distancing from the overall process).

Page 2: [3] Comment [gc18]	graham8	10/01/2012 15:54:00
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Process (initially) acceptance of a referral generates work, a through assessment is carried out. Reading down it would appear that the OTs take a referral and then screen the patient (don't trust the opinion of the referring professional? why? because they don't understand the role of OT).

The issues of being careful is interesting, almost as if they are letting the patient into some kind of club, or that the OTs are custodians of certain resources or privileged which only certain individuals (the ones who meet the criteria) can have access to.

Is this about the OTs controlling what they do, who they will and will not see?

Page 2: [4] Comment [gc20]	graham8	10/01/2012 15:59:00
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The criteria for rehab are those patients who may have a delayed discharge?!

There seems to be a real issue here, the OTs don't have space for rehab because of the pressure put upon them by the organisation and the dominant institution, yet their goal would appear to be to support these structures, yet they feel they can not do this effectively why? because no one knows what OTs do? or because the concept of rehab from the OT perspective is removed from that of the organisation and the dominant institution even though the goal is the same (facilitate a safe discharge...)

Page 6: [5] Comment [gc39]	graham8	12/01/2012 15:57:00
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Difference between the professions, between nurses and OT's what the nurses may see as a physical task, washing and dressing, the OTs see as a developmental task, one which needs further delineation the outcome of which has implications for the patients current and future rehab needs, resource needs. Unpacking the box that is the nature of rehabilitation in secondary care, it is becoming apparent that it depends on who you ask,

the community and if not why not – my current thinking is that secondary care and it's delivery of rehab is shaped by the organisation (needs of the organisation to move patients through rapidly) and the dominant institutions, i.e the dominant professions i.e. nursing and medicine it is apparent from the data (see physio also) that the AHP's are dependent on the actions of the nurses and the decisions of the doctors with regards to actualising and structuring what they want to do

PT Elderly 3

Ok, so we are recording now, so you are happy for me to interview you today

Comment [gc1]: Consent in action

Yes I am.

Ok, good, and you've read the information about the study, and you know roughly what the areas are that I am looking at

Yes

Ok, erm, I am really interested to find out what you do.

So what do we do on the rehab wards, not just general physio as a job.

Comment [gc2]: we

What you do

As a job, as a physio on the rehab ward, well what we do is that we assess all the new patients that come in, it could be a respiratory assessment but generally it is a functional assessment, we look at all the joint ranges and strength before we would actually do the functional assessment and, so that would be sit to stand in and out of bed, walking, standing balance, so we use the TUS and the outcome measures that we use, we try and do it all on the initial assessment that would be TUS 180 degree turn and timed up and go, erm if those are not able to be done on the first intervention then we would come back, and then on discharge we would repeat the same thing as well, and they are all coded with, with er, FIM and FAM things so we can see if we have made a difference or a change, so then after that then we make a problem list and we decide on what we are going to work on erm so it might be balance whatever they need to work, the functional things they need to practice, increasing that, say if it is distance walked, then if it is a respiratory thing we generally we would go through the general assessment and then treat if its secretion retention or what or monitoring their oxygen and provide the pre-intervention or post-intervention informing the doctors, erm and all this is actually and then we have to go to, we have meeting with the doctors we have daily meetings now where we say how they are functionally doing are they ready for discharge and planning their discharge because it has changed quite a bit we are not getting them back to where they were before they were ill, we are sort of getting them just there and then out and then the community will take over, so its quite a different concept now to 10 years ago. So liaising everyday with the nurses with the doctors finding out what the plans are what the changes are in their medical situation and then we would adapt our intervention depending on anything new happening, because they go up and down on our wards. We also work with the OTs, the junior ones tend to come and observe us doing all the functional things, but the senior ones will just go and start doing the walking and whatever before they actually take people for a kitchen assessment or whatever, so the senior OTs work quite differently from the juniors. It's also about working with the more junior physios and the assistants, because a lot of our patients are doubles so we have to liaise if we need two to sit to stand, and we work with discharge co-ordinators we write lots of report, most of the reports are now needed to see if the care plan, to if, to see if the care package is still needed because I think [redacted] went for years, has suddenly found that they were giving people care packages that didn't need them, so now it seems that almost every patient needs a physio report to find out functionally

Comment [gc3]: we

Comment [gc4]: all new patients, this is support by what the nursing staff said, again contrast OT who operate on a referral basis

Comment [gc5]: we, taken to mean we as physio's similarly with OT and nurses

Comment [gc6]: not patient centred

Comment [gc7]: physiotherapy focus is on function with an aspect of acute management in the treatment of respiratory complications

Comment [gc8]: therapy up to the point of discharge, no mention of goals treatment is terminate when the patient goes home....

Comment [gc9]: hierarchy and again the focus is on discharge, as in who is in control, the drs

Comment [gc10]: key a shift in focus for secondary care, treat the patients acute condition then get them out, the focus is moving away from rehab - or is it? Is that the concept of rehab has changed in this setting see below, if it is not rehab then what is it?

Comment [gc11]: Role over lap but not profession per say (AHP over lap) more based on experience,

how they are and the social worker will decide on the care package from that, so not all patients are seen by the OT on our ward but all the patients are seen by the physio and the nurses tend to depend on us a bit too much for erm, waiting for us to sort of get them out of bed but, so, but its generally treating patients, usually they are from 75 onwards but it could be any condition anything they could have from Parkinson's to falls to UTI to, its just a big variety of pathologies and diseases and also mental conditions and some are very demented.

You said that now it's a different concept to what it was 10 years ago, what do you mean by that?

Yes, yes, if they wanted, like before like at [redacted] they came we would try and get them back to where they were before they were ill you know if they couldn't stand up after their UTI we used to get them standing up, but now it is just half way, if they can just walk they can will go home, and then we will give them the rehab at home to get them then, do you see what I mean, doing the think, making a cup of tea for instance you know they are not quite there but they are given like an enablement team for a few weeks to do this and then they might pull out the care package.

Why do you think it has changed?

Because people get so many infections and things in hospital, you know they were staying too long here for the, I suppose it was just a cost thing, I think its less costly, and you know as one patient said to me today because she is going home before, you know, we probably would have kept here another week or two, she said I quite understand that I'd be better at home, that if I go home I can practice you know from my chair with the rehab team and do everything fitting into her little environment and she was quite happy about that, and she is just beginning to walk, today for the first time to the toilet and she is going home tomorrow. So she is happy, she likes that, so this is the difference I mean, so.

Are you happy with that, or would you .

Yes, if the patient is happy and the you know the services are there in the community, for example this particular lady lives with her grandson and he will be able to be there for say if the rehab team go in er, physio rehab we are talking about, erm, or if the enabling team from the social services go in so he can open the door, in other words she doesn't have to get to the door and there doesn't have to be a plan of how to get in if she can't get to the door at the moment, she might in two weeks time so now she needs a key safe, so now all these plans have to go into how it goes, so she, so this lady will be fine to go home tomorrow, but as I said 10 years ago she defiantly would have had another week or so to get her more functionally strong, she has Parkinson's, falls all sorts of things and very bad OA, sort of crunching.

So have the changes in the discharging the patients or the early discharging the patients has that changed what you do, your focus, do you think?

Well its better to, to plan ahead, for example you know I find that this is something that somebody that is newly qualified is not thinking about, how is this person, you know going to get to the toilet at night, can they get from their bed to their commode you know we are working on these functional things so we have lady she has a, she has a fractured, she is in a flay cast, if we could get her using the commode at night safely you know in and out of bed, she would be able to go home with the cast on, but we just haven't got to that yet because she uses the bed pan, the nurses put the bed

Comment [gc12]: Paper work, inter-professional communication, passing on to the community and to social care agencies etc the level of support a patient needs, all patients need physio, but not all OT, the role of OT seems to be somewhat under-valued here, professional decisions used to facilitate decisions regarding resource allocation

Comment [gc13]: The role of a physio-cross ref with what the OTs and the nurse said re manual handling, also what the nurse said about their perception of the physio

Comment [gc14]: Context of practice, complex practice and also here the acknowledgment of mental health issues, cognition, again note that the nurses did not think that the physios were that concerned with this

Comment [gc15]: Concept of rehabilitation in secondary care and the relationship between secondary care and primary care has changed over the last ten years. Rehabilitation in secondary care is now only "half way", in that patients are discharged with the minimal level of functional capacity, as opposed to ten years ago when the patient would have remained in hospital until they were back to their base line with regards to function. The justification for this is given by both OT and Physio as rationale decision based on the increased risk to the patient of acquiring hospital based infections, but also cost (see comment 16) however, it does create a degree of tension between the AHP staff and the nursing and medical staff with regards to role fulfilment, the focus now being on a safe discharge as opposed to the achievement of rehabilitation goals

Comment [gc16]:

Comment [gc17]: Is secondary care ready for this? In addition, what is the role of the virtual ward with regards to these patients?

Comment [gc18]: What if the patient were not happy and there community did not have the services, would a discharge be forced upon them? There seems to be an interesting relationship between primary and secondary care, the AHPs are only happy to discharge, if they think there is adequate support in the community and this seems to be of particular concern for OTs (the balance between a safe discharge and room/space for rehabilitation). With regards to role and boundaries, the ... [1]

Comment [gc19]: A key part of the case write up is to map the community services in Newham

Comment [gc20]: Community based rehabilitation begins in secondary care, discharge planning starts as soon the patient is admitted

rehab
24/02

pan under her bum about 5 times a night so we haven't quite got to the stage where the nurses will do that in the night and then she would go home before the plaster is off because its probably going to be another 6 weeks before the plaster is due off.

rehab 25/02

Comment [gc21]: Rehabilitation vs care, the concept of rehabilitation is not shared, or the same across the professions in secondary care, i.e. NS vs Physio

You mentioned that you think that the nurses depend on you a bit too much,

rehab
25/02

They do, its getting, at [redacted] they, it seems that they, they are not rehab based trained, they are not thinking of rehab they are thinking of acute care, so its a mixture now, at [redacted] s they had to be rehab because they had no night doctors so they had to be medically stable to get there where as here they are sending people from 5 days from the acute ward, so they are still quite acute still quite ill, so they, I know that they are very busy and that they are spending so much time with the ill people to actually get someone to walk to the toilet to have a shower or a wash in the morning, its easier for them to give a bed bath you know what I mean. Its very time consuming to wait for people to do things for themselves, yes I can see why they don't have the time.

rehab
24/02

Comment [gc22]: See comment 21, but also cross reference with NS and OT.

The dripping tap, common learning etc was supposed to address this issue (to some degree) of interprofessional working, however, the tensions and the varying frames of reference between professions in this one organisation appear to remain. Role and boundaries are not just about what you do but also how you perceive what you do, the concept of rehabilitation being an excellent example

And again does that,

organisational
values

But a few from [redacted] s are still there, they will be out of bed standing at the bed side having a wash you know standing up the patient while they are having a wash or walking them up to the toilet, where as the others will be Oh no we are short staffed, so I think the current manager on the ward I work on, she is not rehab based so it kind of comes from there really she doesn't seem to understand the concept of it, so what else do you want to know from me?

Comment [gc23]: Change in how rehabilitation is delivered

This notion of reducing in patient bed days is not new and there has been quite a lot written about the reasons behind it and the evidence supporting community based rehabilitation, so why is it coming up here?

professional
I

Do you enjoy what you do?

Well it's the patients, its nothing else, I have problems with the nurses and other physios and all that, its just the patients I love.

rehab
25/02

Why, what makes it so lovely?

Because it is so witty so quick, every day they make me laugh, and you know they also appreciate you they, most of them are English still, we have, we're not sort of multi, multi-cultured that much, very very few compared, how can we say to the inhabitants of [redacted], so most of them are English, and they are just first class people, they are not troublesome yet, you know the young English people can be quite troublesome patients, no they are lovely I really like it.

So its not what you do its who you are working with?

professional
I

Yes I think so, but you see what you have done, you know you see that they have improved, so you know that's good, I mean although I don't think that way but like the assistant said, wow, they did a good job, wow look at how much better they are, they get such a buzz out of that, I tend not to do that now, you know not after all these years because I'm moving on to the next one, you know, but I can see oh yes I used to be like that yes its is, it is lovely to see that they have improved so much, I get a joy out of it.

Comment [gc24]: The rehab ward in the secondary care setting is taking patient who are unwell. There has been a shift in the role of organisations such as acute hospitals with regards to rehab, their priority is the assessment, diagnosis and treatment of acutely unwell people, but as a result of this where once they may have been a rehab agenda there no longer is. The significance of this for AHPs? Well there is defiantly role and identity conflict and a sense of frustration between the professions. Why is this the case? May be an explanation lies in the sociology of the professions after all, autonomy, professional identity and professionalism, these are brought into question in this environment as AHPs are being forced (bit harsh) to act in a way which is at odds with how they were trained to behave...

Comment [gc25]: Not a nursing thing but an organisational thing...

Comment [gc26]: Speaks for itself! But cross ref with the nurse- who's concept are we talking about here?

Comment [gc27]: Professionalism, psychology of self fulfilment

Comment [gc28]: Change in attitude of the patients towards staff (again cross ref with the nurses with regards to their relationship to patients and families etc

Comment [gc29]: See comment 27

So you don't get you are not, if I am interpreting this right, you are not getting a buzz out of,

Not that much anymore because I am moving on to the next one, to the you know to,

So what gives you your buzz now?

Well just moving on to the next one really, but also may be I am retiring soon so may be that's a buzz, but I do really enjoy the client group yes, the patient group are a joy to, to help and to what ever we are going to do with them, I mean they are usually very co-operative and you know appreciative and whatever. They can be very difficult as well I mean the demented ones, you really need to know how to handle them and they can get quite angry and aggressive but once you have an understanding they are usually ok.

Comment [gc30]: Able to work in a 'traditional' professional role, i.e. that you are not questioned etc etc.

You mentioned kind of briefly, I don't know if it was an off hand comment, the kind of cufffuls with the nurses.

Lack of understanding of OT

Well we have a lot, a lot of little things like that yes, because as I said they are so busy, we have done a lot of rehab training with them and then, then new staff just don't seem to have the concept of, just washing them in bed and leaving them there that's it.

Prof face of Ref.

Comment [gc31]: Does not seem to be something that the nursing profession considers to be important....may be

Organisational values.

Why, do you think ?

medicine vs rehab

Control over work

It is the sister, it comes from the managers, although we go to her and say please you know, I can not physically get all these people out of bed, and these are two very senior nurses, one of the sisters on the ward, there is this lady I have been seeing for a week, shes going home next week she still had a bed bath today, she has never walked out to the bathroom to wash herself but she is going to have to wash herself when she goes home, oh but I gave her the flannel to wash her face, and I said but that's not helpful now is it when you really think of it, is that helping this person, she has to get out of bed herself and walk out to the bathroom, its, its quite exhausting that part of it because its almost like, if you don't understand there is a problem, you know I can't solve it for them, you know, but if you just can't see it, you can't help so you sort of have to give up sometimes I think, or go to, it would be better coming from a nurse because we do have a physio nurse thing, we do have a nurse now who is called, elderly specialist nurse, consultant nurse, and she did organise when she was the professional development nurse a few years ago, she did organise all the training we did rehab skills training, and I had two hours of that training in the day, and that I enjoyed teaching, you know going through things with the nurses it was really interesting, and all of them said it was excellent and that they enjoyed it, because as I said the new staff you the new staff they haven't really handed it on to the others who aren't as enthusiastic

S/A

Comment [gc32]: Cross ref with the sister, however, is this an example of where the general culture on the ward is not one of rehabilitation but of care

H/P?

Comment [gc33]: Culture clash, this is the numb of it with regards to rehabilitation, the two professions have two very different concepts of what it means with regards to their practice and because of this there is conflict, there is clearly an issue, a physio nurse thing, but this is not everywhere (find examples). But it may be that for every beacon site there is or are areas where multi-professional working is not a reality, no matter how much we want it to be and the comment regarding new staff would imply that the measure put in place to address this (such as common learning etc) are not working. Also there is the issue that you can alter system etc regarding professional education, but if the organisational culture overall does not facilitate this then you get conflicting messages.

Prof face of Ref

role overlap

You talked about, or you mentioned that the junior OTs would spend more time with you than the seniors

No not that the spend more time they sort of say, oh can I come with you when I see this person, you know, its almost like they, you know need to watch, how they get out of bed, how they sit to stand, how they walk, where as the seniors will just go, you know what I mean, without the physio there and do things with them which is great because if I see them, in the morning and the Ot sees them in the afternoon and its still walking to the toilet still do some more functional things so that's good, but as I said the juniors tend to, they are usually newly qualified you know, can I see what you are doing with this person rather than just saying oh I have been referred this persona and just getting on with it, they tend to do that.

Comment [gc34]: An indication of what is the role of the OT in this context and what is taught at undergraduate level. There is this acknowledgement that AHP training only develops practitioners to a point, their socialisation and worked based experiences then contributing to their concept of practice role and identity, but also this brings in the exposure of dissidence between the two (professional role vs organisational role), in this context this appears to be felt more acutely by the OTs than the Physios, again the data indicating this

Is there a lot of overlap between what you do and what the OTs do?

role overlap

safe DC

system shipping role

everybody needs physio

everybody needs physio

Oh, of course there is, there is an awful lot, and all the functional things that we do what the patient has to be able to do to do their ADLs isn't it, so sometimes they do a one off assessment usually, like a kitchen assessment the OTs would do a kitchen assessment or a washing a dressing and then tell the nurses what to do, but they don't really do much rehab on our ward at all, its more like discharge planning.

Comment [gc35]: Contrast this to what the nurse said, (we use the other professions for out goals...)

Comment [gc36]: Reinforcing what the OTs have said

Why is that?

I just I suppose because once it was called a rehab hospital at [redacted], they never changed the number of people there were and so the discharges are so important so they would be doing more the access home visits, home visits, ordering equipment for people you know, measuring up for hoists or for whatever equipment is needed for discharge, they tend to do a lot of discharge planning erm, but they don't see all the patients they are only referred a few I would say maybe 50% of the patients are seen by the OTs but they are obviously all seen by physio.

Comment [gc37]: Role of Ot as seen by the physio, another thing of interest here is the goal of the organisation, i.e. discharges are so important

Is that because they all need to be seen by a physio or,

Yes we assess them just about every body needs, there are very very few that come I can say you know are up walking good balance and they don't need anything.

Comment [gc38]: Every patient has an issue which needs to be addressed by physiotherapy, a physiotherapy need; physio's are therefore an important part of the hospital set up but their role has changed over the past 10 years from restoration of full mobility/function to helping the patient to be able to cope @ discharge. The role of secondary care is no longer that of providing all treatment, now treatment (from an AHP perspective is seen as a continuum from secondary care to primary care, however this is not without its problems (see comments re decisions to keep patients or discharge them based on the community facilities/services available), also within this is the need for secondary care staff to make sure adequate support is available in the community (hence the role of the OT in this setting, OTs are acting as the bridge between secondary and primary care)

And is that the same for OT?

No, the OT, they only refer, some people have had OT before we know that, if it is a readmission for example, or they are just not needed, the family are happy to live with the family and they say no we don't need anything, or they are totally clued in and say no I had all this done when I had my knee done ten years ago they don't need anything else, it depends, but the physio, they would have been discharged you see if they were ok functionally, form the other ward, the admitting ward, where as ours is usually the second ward they come to, usually, sometimes they come straight to us from A and E but usually it is their second ward so if they come from CCU or any other words then its usually a functional problem that they have got so that is why they come to us, that is why we see all of them, there are very few that come to die or come, you know are bed bound and they are going back bed bound to the nursing home, very few, but even those you need to check really and see if there is anything specific.

Comment [gc39]: Underlining the assumption that OTs are not involved in rehabilitation only set up.

Comment [gc40]: OT's just issue equipment

Comment [gc41]: Is this rehabilitation?, also how does this fit with "when medically stable then discharge"? The patients on this ward either have not got better fast enough or they have a functional problem that can not be managed in the community - which is it?

You have been working in the NHS for a long time

Mmm

Can I ask you how long?

Coming up to 26 years

Lots of changes

Yes

The way, they way it is now, do you think it is better?

No, I think really when you said this was about may be you know because there is a lot of overlap say with what we do, no I think that generic workers would be very very useful to the NHS, I really do,

Comment [gc42]: Acknowledgement of role overlap and the need for a generic worker

role overlap

U10

we had for example a rehab, we call it a rehab assistant but they were working with speech and language Ot and Physio, he was only was there for 6 months and he loved the job but he has come from a job before which was thousands of pounds more so when he come through he said that fell though so they decided to call me back, he was so sad and it was wonderful having him, but they never, the trust, the therapy services never replaced him, but what he did was, he would, I would tell him this person lives alone, washing and dressing as I said OT isn't involved with everyone, so I would literally be telling who needs to have washing and dressing, so he only had two people, because it takes so long, when the person is doing it so he would have two people for washing and dressing in the morning and then he did all the physio, he used to work at the weekends and he used to walk them up and down the corridor going for these extra long walks you know that we wouldn't be able to do during the week say, the he'd be doing the speech and language because we used to have stroke patients at that time as well on our ward as the stroke team would only chose the ones that they thought rehabable so we tended to have the more severely impaired people so he would, whatever the speech and language told him the exercises or what ever he would do that for the speech whatever, and it was wonderful, it really was good, it worked really well, but you need the senior or the physio there to be directing him.

role overlap

Comment [gc43]: The role of the generic therapist. Delegation of task for another profession, is suggesting that more OT's are needed, or that, what OTs should be doing takes too long, and that they do not have time to do it anyway because they are distracted by their role as discharge facilitators, or is it that the trust did not keep him because this "type" of rehab does not have a place within the organisation, it is something that can be addressed once the patient is in the community...?

Comment [gc44]: Stages of rehab? Is elderly a dumping ground...?

It sounded what you said just then though, that you do, that you do a lot of what the OTs do.

Yes we do.

role overlap

So, even at a senior level, is there justification in saying that there is no need to have a physio and an Ot just have a generic therapist.

The thing is the Physio would need, because the Ot does all the home assessments that we haven't really been trained to do, I mean all the, you know we haven't done all the complicated hoists and that type of equipment, but may be that could be separate all that equipment stuff that is needed at home, but generally all the functional things, the ADL, you know all this could be into one body really.

Comment [gc45]: Role overlap but also distinction, the Physio seems to be suggesting that with regards to rehabilitation, functional rehabilitation there is overlap between OTs and Physio's what makes the OT's role distinct is the assessment for and issuing of equipment...however if you talked to the Ot's about this they would say that there is a difference but there is not space for them to do (physical or ideological)

Why do you think it is not?

Professionalism

I don't know, I mean its just so, oh this is a job, you know you don't understand what are you going on about? You know, like one physio saying I can't show someone else how to measure a stick you know that's my job how to give a frame, I said but you know surly we want the nurses or the rehab assistants to be able to give a frame and get this person going it's a waste of days you know waiting for somebody, we're so highly trained to give a stick or a frame, I can't figure it out really.

Comment [gc46]: Protectionism, but also of what, it seems that there are some elements that the physio is willing to give up but not others (is this what she is saying or am I reading more into this than there really is?)

I read a lot erm of kind of policies and strategies etc that, everything,

Competencies

Competencies is a big thing, but this drive for the right person doing the right thing at the right time etc, and multi skilling

Yes, yes

But when I look around the hospital I don't see it, why?

rehab
29 coc.

do
role
overlap

Well, this is how I have been trying to get that ward going, how it would work at [redacted], I would literally com in on Monday and the nurses would say to me, [redacted] this person come on Friday and I have given them this frame but I'm not quite sure it is the right height can you come and have a look for me and the are off to the toilet, everybody would be hoisted they would have decided how to get each person out of bed, which equipment, its magic its done, and then here trying to get that its like, so we have actually gone backwards here, I looked at it with them so yes they should be able to , all the rehab skills we did go though, so looking at the height of a frame and how to use them and instruct in different things, so yes that's what we need really, that's what is needed in the NHS.

Comment [gc47]: Depends on what the goal is...

Comment [gc48]: Multi-skilling is what is needed in the NHS, but there are barriers to this (explore in the lit)

You, you are a physio,

But I understand that there are many things that can, for example, for example the rehab assistant we trained in all the anatomy and all this specific things, but they should be able to understand how we sit to stand how we do all these functional things and how to instruct them, or why its not possible to correct it, so knee flexion or what ever it is, so they should be able to do all these things, but I can understand that, and I understand that the nurses, they haven't got all the joint range and you know and all this and it is more difficult for them to appreciate that if somebody can't lift their arms what can't they do, there are so many of them have bilateral things they can't, the can't reach their table for a drink oh I didn't think of that, you know little things like that and there is this person stuck. I understand that we do special things because of the long training that we have on these specific wards we are talking about, generally physios do do very special things with their, you know outpatients and all that, that no one else does you know treating joints and different things, but generally on the ward they do the mobility things and functional improvement and balance improvement things to get this person you know as functionally able as possible whatever that you know their potential is and I think it is it tends to be the work tends to be a little more generic and be able to go and do everything concerned with that patient.

Comment [gc49]: Cross ref with the criticisms of care on elderly wards, 2011

Do you consider yourself to be a generic worker?

No, no, because for example I wouldn't erm, you know I wouldn't go and make a get somebody to do, well ADL I look at can they dress themselves, can they pull up their trousers etc that kind of thing, but I wouldn't actually be going and getting somebody to make a cup of tea and telling the OT that I've done that you know what I mean, erm

Why not?

Because it's a waste of my time because I have other things to do, and I have such a big patient load if you have somebody else doing this things do you see what I mean, like taking them all the way off the ward to make a cup of tea, I wouldn't be going to do that, generally, for example, if I, if somebody needs cleaning I take them to the toilet, if they were really dirty, I mean I'd let the nurse, call the nurse to do that, I'm not going to put clothes on and wipe their bum, spend time doing that when I still have so many patients that don't have standing balance do you understand because there is the potential there to be very generic but I don't have the time, there is usually one physio for 26 patients and we can't see all the patients every day the whole time we are prioritising the maximum we can see is 17, but the juniors can only get around about 11 out of 26 do you know what I mean, so I really do have to leave things for other staff.

Comment [gc50]: General ward work is generic? Functional rehabilitation only draws on a small aspect of what is required of a physiotherapists and because of this it would be possible having more people applying the basic skills

Comment [gc51]: It only works if we all do it if not then we remain the same....

Comment [gc52]: This is slowly forming as an idea or general theme...the relationship between the role and goals of the organisation and the different professional institutions working within them. The relationship is not static but is being constantly negotiated (see example of we had had training, we have meeting etc), and the different institutions are trying to find their place, define their role, this creates area of friction (scuffles) and dissatisfaction (this is not rehab etc) with individuals trying to make sense of their place as a professional in the overall workings of the organisation. It appears that the professions have their roles defined through their undergraduate education and socialisation, then this is redefined or negotiated and also used as a referent point to then interpret their role within the work place with some institutions and individuals being better placed to do this than others....(can I support this final part?)

Refine & edit

role overlap

System
shaping
role.

up to her!

X You mentioned that some areas of physio like MSK out patients are specialised, do you

They are not specialised, but they do things that say the OTs wouldn't do or the nurses wouldn't do

What makes you a physio?

Well physical therapy it is, on the wards it is about function really, basically

Isn't that what the OTs do though, I am struggling

Yes but they do ADLs, its more like they fit that function, we are getting that function right and once they get the standing then they take them to the kitchen, You know, I mean we are doing lots of balance things around the bed doing these things, like bending and moving and moving the glasses around or whatever, to turn into their function but it will be the OTs that do their washing and dressing assessment of the patient and deciding if they need a care package or not, the ADLs really. So they, they defiantly the senior OTs will get in there and say, Oh look if you don't practice getting on and off the just like an assessment for the care package that they are thinking of, as a one off just to see how they are getting in and out of bed or on and off the toilet on the ward, where as we are doing it daily, do you know what I mean, we will be doing it daily daily just to improve their their function.

Prof F of R.

Comment [gc53]: The distinction between Ot and Physio, but has Physiotherapy now moved on from this, are the two professions more blurred?

Ots contextualise what the physio's do, but I feel this concept has changed within physiotherapy (note this is my perception as a neuro physio...)

Prof F of R.

Comment [gc54]: The goals are different?, the orientation, interpretation of the task is different (two heads are better than one...?)

I've done quite a few interviews and something that has come up on a number of occasions is, the philosophy of the hospital with regards to rehab and discharging erm and, a few people have said to me that the focus is on safety as opposed to rehabilitation, and one rationale for that is that the hospital's just scared of being sued and,

rehab 29 core.

It could be that it could be that, and that is happening now on our ward, its really heartbreaking to see people in bed tethered to an alarm, can't sit out because, and can we have, for example at the moment there are so many nurses on the ward because we have 3 or 4 students, can someone stay in this bay and see these people sitting in their chairs, do you see what I mean, no we don't have the staff so this person is tethered to the bed until I go and take her for a walk or what ever the person wants to do and then take them, I have to put them back to bed because I am going to leave the bay and tether them to their alarm, so is that helpful [REDACTED] But as you say its safety.

It is you, I want to know what you think

rehab 29 core

It is a safety thing, its er yesterday I just said to someone I said, because I did ask it again on this particular day, three of the people will always be getting up if you leave them in the chair so I understand you know why it is back to bed, but also I can't figure out when there are so many people around why you are telling me you have no staff, couldn't one person just stay in there for three hours, two hours and at least these people in bed moved, walked and then back in the chair you know, so they can sit up for lunch with somebody always there, its possible because I came up yesterday and I said now if you don't want to do something then you won't do it, it is always possible to do something if you compromise to do it but they said no they don't to do it, I can see that three they want them to stay in bed, but the other three could defiantly be sitting out and eating and.

Is the hospital rehab focused?

Impact on pts.

Comment [gc55]: Quite a graphic picture of how patients are treated in this ward environment. Rehabilitation is a risky business and the organisation and the health care professional's role is to minimise risk. In addition to this, a lack of consensus of what rehabilitation is means the patients are missing out

Comment [gc56]: Stay and do what, this is not the role of the nurse, it does not fit with their view of rehab....

Comment [gc57]: They being the nursing staff

Comment [gc58]: Cross ref with what the nursing staff said, they are rehab focused but again who's definition of rehab

Comment [gc59]: OTs have issues with the culture, Physio's have issues with the nursing staff. Why? Proximity and working relationships, presence on the ward etc, chances to interact?

capde.

Rehab 24/7 *

organizational
values

do medical
vs
rehab

I don't say now, no they have never been, [redacted] I must not mention names, on the other rehab ward the doctors are more rehab focused because they came from [redacted], but the patients tend to stay longer on that ward, now my ward is a very fast turn over, more fast turn over than the other wards, they might think that that is a good thing, it reflects on the physio it is actually that we are getting people out earlier you know that they are not getting better (laughs) but you know the hospital may think that that is a good thing, but its not necessarily, but I understand that they need the beds, they have lost so many of the beds, you know cut down on the beds for the elderly, generally in the hospital by a whole ward I think they have cut down by 29 beds, so I can understand the whole concept is in and out I understand that, but its now medically, oh they are medically fit so home, you know where as before at [redacted], it was well they are medically fit but now they need another week or two you know like to get back if they have been sick for two weeks, it might take 4 to get back on their feet properly you know its that kind of thing, but now no, right medically fit right home, there is no understanding, but that comes from the doctors its not just from.

I've er

medicines
us
Rehab!

We're not doing anything now for the patients the Dr says, right home tomorrow.

I have got the chance, and don't worry because I will take all the names off this, erm, I met with Dr [redacted] and Dr [redacted] last week to ask if I could come to the MDT meetings and just observe whats goes on, erm, they are fine with that they are happy for me to go to those, in your opinion what would be a good meeting for me to go to from a so, basically what I would really be able to do is to be able to see the contrast of a rehab meeting and a non rehab meeting.

Right, so you would have to go to the [redacted] one, [redacted] because that is fast discharge, and either [redacted] or [redacted] ward because they are both basically the same but not on the same day, so you could just choose, or maybe you should go to one of each because as I said they, one is more from [redacted] and the other is more, well we are doing nothing for them now we have finished with them medically right home

Which one is which

That's my one

And which one is that

The fast one

[redacted]

No [redacted]

[redacted]. But [redacted] is the acute section

Yes that's [redacted] ward

Yes but its [redacted] now, so they are the fast turnover, so they either send them home after a few days or they come over to us.

Are you going to be sad to retire

S/A ideology!

Comment [gc60]: Two issues here, the first is the comment about the difference between the two wards, they have the same function but there is a perception that they work differently, this being due to the attitude of the consults (dominant institution). They keep people for longer, where as her ward gets them out which the hospital likes and makes her look good but she is not getting the patients better in her eyes 9i.e. full rehab). The contrast between the organisational goals and that of the dominant institutions, but it is not uniform, DR Gill came from St Andrews and therefore has this more traditional view where as the consultant on her ward does not, they are medically stable and out.

So there is an alignment her between the dominant institution and the organisation i.e discharge patients but this is not reflect across all medics.

Comment [gc61]: Medically dominated!!

* = save section } notes

No

(Laughs)

No I love it don't get me wrong but I have so many other things that I want to do and I find now that because I am 60 that I am too tired in the evening to do anything else and, even at the weekend I am too tired to do anything else, which is silly. But I have enjoyed it, that's why I have stayed at [REDACTED] because I have enjoyed it.

You won't be sad not to be a physio anymore

No, even I think, when was the HPC thing go to, next year

2012

2012 yes I won't register and I'll stop paying CSP.

And doesn't matter that you not going to be a physio

No, no. I am not the person that says when they meet somebody I am a physio, you know its not, my family would say she is a physio she is a wonderful physio but, its only its just not (laughs), I don't know I've never been sort of, a big ego or whatever you call it. When I first qualified, yes I was very happy to be qualified for the first few months and Oh I am a physio isn't that wonderful but after a few months that past (laughs). I though you were going to ask me what the difference between my job and the nurses and the OTs

No

Have we nearly finished?

Its up to you, as I said I am just interest to hear what you do and what you think about what you do.

Oh so that is all it is ok. Well I think it is an effective job it really is we really make a difference. Do you know that the more senior you are the more of a difference you can make and the more accurate you are in what you do, I do know that.

Why do you think that is?

I think its just probably that they well you all would call it clinical reasoning now wouldn't you, you know you see so many thinks that your brain will just compute and workout that this person can advance and avoid giving up too early, and of course there is knowing much more you have many more skill in handling and moving people and getting them up, it does make a big difference.

How do you think this virtual ward thing is going to work out?

Oh I hope, I think it is going to do well, I think it is brilliant, already yesterday I was telling them about oh that would, would be good for the virtual ward, (laughs), but they are not taking it on board though, but yes I can think of one person they are planning on sending home who would be very good for the virtual ward, with a matron and everyone monitoring him, so he doesn't have to come back into hospital, so I think it would be yes, it will seem to, I know that [REDACTED] have been

Comment [gc62]: Clinical reasoning expert novice

with it for 4 years and they have not got all their figures in but it would seem to be really a good thing.

I was chatting, a friend of mine is a physio manager up at [REDACTED] and he is having constant battles with his manager around what physios do, because his manager thinks that physios don't rehab in the inpatient setting, do you agree with that?

rehab
24 case

Well we are trying and the defiantly improve functionally from the time they come in, when it needs two of us to lift them into standing, for example the lady who is going home tomorrow Oh, an effort to get her out of bed, today she get out of bed herself, so that's taken two weeks, so if that's not rehab I don't know what is, and she is so happy, she is so, because she had a fall, she all this stiffness and pain and everything when she started, so yes doing really well.

Comment [gc63]: Rehabilitation in secondary care!

Do you ever think, you know if the Dr say medically stable they can go home, do you every think, oh if I had them for a few more days they could

They actually listen to me though if I tell them that they will keep them, it is not as bad as that now they will listen.

Comment [gc64]: Negotiation does happen but it seems to be an individual thing, they listen to me (cross ref with physio acute)

So its not completely

Safe D/C

No, its not set, all patient are assessed on the day of discharge and sometimes what we have to do is stop a discharge if something new has happened. I say to all the juniors at the start of their rotation, I say they must assess them at the day of discharge, not only do we sometimes have to stop a discharge because something new has clearly happened to this person, but also when we got the phone calls from the community, and they can't get in and out of bed when we sent them home you know, they can't answer the door for the carers or what ever, we need to know that when they left hospital they were able, so if they can't do these things then some new event has happened and we can categorically say that yes, so I hope that's what the juniors are doing when they discharge, they are assessing them on the day of discharge, I mean that is one of the things that we do do we find out who is being discharged and then we go and assess them, and as I say a few times we have had to go and say no, you know they are not well, something has happened and the Drs will go and see them.

Comment [gc65]: Communication with primary care about the patients function, links with primary care

Comment [gc66]: So the discharge decision is not made by the therapy staff, they have to find out who is going.....

2-16 link

Do you ever discharge a patient before they are discharged from hospital?

No, we, it is not a good idea to do that, they have been done that, but because they go up and down, now, if we discharged them and that we don't see them and then they do deteriorate, its not a good idea because then they, with all this EPI, they have to re-refer and all this cufffull, so I said no look, I know that our notes are in the medical notes so the Drs can see that oh they have not seen this patient for 5 days and on the other ward they come to the poor juniors and say why have you not seen them, but you know you need to write that they are functionally independent at the moment and I will monitor, you know visually monitor them you know and restart if needed, and something like that then you won't have them coming to you, so no it's too much trouble and as I say they are going up and down like this and patients often, they don't just go straight from unwell to well, they fluctuate in so many things happening to them on the ward, so that's what I think is the best service, not to discharge from physio until the day they are discharged.

System
shaping
role

Comment [gc67]: If a patient is in hospital they have access to physiotherapy regardless of whether they need it or not, this is not the same for OT, so the two professions are rationed differently within the organisation

And is everybody that is discharged from hospital referred to community physio?

No, very few, very very few, we have two today we are going to do who are going to be discharged this week, so very very few, some people will do more, I have noticed that you know some physios who almost refer everybody, but I don't, hardly anybody.

Comment [gc68]: But how does this relate to the fact that patients are only getting halfway there with regards to their function?

Why not?

The community physio have tended not to go in immediate, it has tended to be two three four weeks down the line and we don't have that time so if I wanted immediate rehab I would do to the rehab service

Right ok

Er, now when I say community physio now we have to refer because they have split so when we put in a referral we have to put in a rehab one which is actually to the rehab assistants but it is on the community physio form at the moment because that is what they have told us to do, I suppose until the things, the areas get their own referrals, letter headed paper, I don't know, but very few, I referred to a neuro community physio last week. It is about the speed, something's you just can't wait. Oh yes I remember one, quite a while ago actually the community referral I made physio, for somebody who had spinal decompression at the [REDACTED], partially paralysed you know quadriplegic but was making little by little progress, so I thought the community literally would have to keep her on ages, and the daughter was absolutely first class at doing what ever exercises we would do with her took everything on board so I thought they could monitor her maybe every few weeks give her more exercises to do, so that kind of thing I referred, but it usually just the rehab assistants that we refer to usually.

Comment [gc69]: Note this is important with regards to mapping community services in Newham

Comment [gc70]: Changes in the way community services are structured etc leading to fragmentation of patient care

Excellent, well there is nothing more I want to ask you, is there any more you want to say?

No there is nothing I just hope that they do some kind of generic thing I do think it is too costly having all these different people

Lots of arguments against it

At [REDACTED] I used to do the home visits because we didn't have any OTs, but all I could do then was say whether, because I couldn't order any equipment or change anything, so all I could say was whether the care package was ok and say if they could go home yes or no, that is all I could do, I did one a day. But the actual equipment is a big course a big, it's a generic thing to do, but generally on these wards, on rehab wards I think a generic person, fewer physios and more generic would be a good idea.

I, would be inclined to agree with you but there is a lot of resistance towards it

Oh I understand that, but, because the rehab assistant that they are training now what are they called rehab assistant practitioners we have one on each ward now they are still training, but he is the only, not the only, but one of the few who would have them out in the bathroom and all that

And are they a band three or a band 4

A band 4

Right,

I am going to stop the tape now

Ok.

What if the patient were not happy and there community did not have the services, would a discharge be forced upon them? There seems to be an interesting relationship between primary and secondary care, the AHPs are only happy to discharge, if they think there is adequate support in the community and this seems to be of particular concern for OTs (the balance between a safe discharge and room/space for rehabilitation). With regards to role and boundaries, these seem to be created by the inter-relationship between the professional frame of reference of the individual and their profession and that of other professions and the needs of the organisation and the degree of support offered by other organisations. Here it seems is the professional role, getting the balance between the patient's preferences and the level of support.

Nursing staff elderly

You're happy for me to ask you a few questions?

Yes, sure,

Good, erm,

Shall I put the meeting in progress, so we are not disturbed,

Yes, ok, I won't take too much of your time, so I am going to be fairly direct with the questions, ok, erm, you work in elderly

I do yes,

And you are on is it [redacted] or [redacted]?

[redacted]

[redacted], ok, erm, what is your view of the physios on [redacted]?

Erm, first of all they rotate anyway, so you can't have, like, like we do staff for years and years, so they rotate every four months, and that is their normal, doctors change over every six months that is their normal working pattern I suppose. We work in partnership with the physiotherapist, the assessment of patients what we have been trying to sort out, er, between the physio and the nursing staff, erm, we'd go for manual handling and we are supposed to assess our patient and do what exactly what we are supposed to be doing if you assess the load you know you.

Yes the tile thing,

Yes, it all depends on the assessment, if you can not do it on your own then you get help, if two people can't do it then you use the hoist, so that's our nursing model or something, then the physiotherapists their assessment is different from ours, well we used to have like, I wouldn't say problems, more like misunderstandings, er, nursing staff would think er, if they can't do anything with the patient its physio's responsibility but I have so many meetings with the physios and their managers and I related it to the staff at the ward meetings so now it is, we, we work more better, you know within the team, you know they can have, when we have sorted it. Er, the physiotherapists explain that the assessment could be, they could assist the patient from bed to chair then walk them to the toilet and they have done their job (laughs), why the nursing staff, that was before the meeting, they didn't understand that if the physio walked the patient to the toilet they should walk them back until I sorted that out, so they're assessment is that walking the patient to the toilet, its not their responsibility, so yes it is fine, and I have tried to explain this fact to the staff as well at the ward meeting.

Do you agree with that?

What we are supposed to be doing, erm, I do, I do because erm, they will do the assessment they have a lot to write about and they check is the patient is in pain, you know the joint and, which the nurses don't, we the trained nurses do because if they are in pain you know we give them

different perspectives
leading to misunderstanding

Physio's
not permanent

Physio
aligned
to
mechanics

nurses
view of
physio

lack of
understanding
of rehab

medical
vs
rehab

Comment [gc1]: Why did I start here, is this a reflection of my bias towards physiotherapy what are the possible implications of this?

Comment [gc2]: Nursing staff, again when the respondents talk about their team they are referring to their profession

Comment [gc3]: The example given is manual handling a nursing issue, there is no mention of rehab

Comment [gc4]: Different interpretations of what should be done with the patient (not worded very well)

Comment [gc5]: What is going on here? Sister is acknowledging that there have, in the past been issues with regards to the relationship between physios and nurses, the nurses thinking that the physios were there to mobilise the patients and because of they did not have to, the mobility was the treatment and that is there job/role - this is about the fragmentation of activities in health care, a result of specialisation (and you could say professionalization of healthcare roles). The physios needed to make it clear that mobility was part of an assessment, why, because this is more complex and therefore requires a specific profession to carry it out where as the nurses can mobilise the patient, it is not unique to physiotherapy. Again it is this lack of understanding between the different professions (relate back to OT1 elder, however the issues here are different when compared to OT's and the nurses)

M308

Medical vs Rehab

medication, and the junior staff if they tell us they are in pain then we give them so, but physio is more, the assessment is more detailed than what we do, er, so what do I say

Comment [gc6]: Relate to comment and interpretation 5

Rehab 29/002

Do you think physios have got a role on the ward, do you think they are important?

Very much so, in erm, a rehab ward, Physio and OT, without that, actually all the multi-disciplinary, the social workers, when patients are admitted or transferred to us they are not well, they are, they do the assessment, the physiotherapist, if it is breathing they get involved erm, you know chest physio so it is not only walking and you know mobility, and they do the chest physio and they are well trained and they get help from the respiratory team as well, erm, they are actually very active, its not only walking patients they do the assessment, they do chest physio they do bed exercises, erm, training as well for new staff, all the students they work, they do one to one with and explain what they're role is

Comment [gc7]: Compare to OT 1 elder, is it a rehab ward

Comment [gc8]: Acknowledging that the patients on the rehab ward may be or are still acutely unwell

Comment [gc9]: Acute respiratory care

Team work Nurse of OT

What about the OTs?

The OTs very visible as well, we are quite happy with them, erm, they come to the ward every morning see the patient, sometimes it is joint, like I said a joint session they team with the physiotherapist as well and do a joint session, like transferring, making decision together with the physio and again reporting at the MDT, erm, and recommendations as well, like if a patient takes two to transfer or mobilise then like you mentioned in your introduction straight away the OT will start thinking about discharge destination you know, they work together with the physiotherapist and they have like goals and targets like oh well we try another week, then after two weeks they can feedback to the team and say what they think this patient can not rehabilitate then the whole team including the medical team will start making decisions around that, yes

Comment [gc10]: Evidence of joint working with regards to assessment

Comment [gc11]: Goal is discharge

What is a nurses role in rehab?

Erm, the nurse's role in rehab, that's a one, we enable patient from when they are not very well, so somebody with pneumonia who can not do a lot, who is very sick, on anti-biotics and erm, so we maintain what we call the activities of the daily living breathing, communication, eating drinking personal care elimination, up to care of the diet so we follow you know those 12 processes, that is what we do, if they get better we could start with sitting them out encouraging them to mobilise, we don't wait actually for physiotherapist always, we just give them breakfast and wait till physio come we carry on doing things and if we can, we work together with the physiotherapist

Ok,

So actually from the admission to the discharge we get involved, erm, personal care here, which is different in like medical ward or the acute medical ward, what we do encourage them, we have got so many bathrooms and toilets erm, we have bought perching stools and bowls in the sink you know and the sink you can adjust them as well according to the heights of the patient, so we treat them as if they are at home sort of walk them to the toilet they sit on the perching stool and wash themselves, we give a mirror so the men can shave themselves so we do that as well which is proper rehab,

Comment [gc12]: Nurses concept of rehabilitation, unlike that of Ot and Physio, this 12 processes needs unpacking further but there is or appears to be this acute focus

Comment [gc13]: Role overlap with the physiotherapists

Comment [gc14]: Nurses concepts of rehab, what is interesting here is the acknowledgment that here it is different to other wards, medical wards, the nurses view their activities as constituting rehabilitation, however, this is contradicted by the Ot and to some degree by the physios

Comment [gc15]: Proper rehab

Rehab in 29/002

control over work

Erm, you mean on the ward

Yes,

All of us, everybody actually, for rehab ward we all you know look after patients, its not like oh well its doctors job or, we work together

rehab 24/7

Is nursing on this type of ward, you say it is different compared to medical wards

Yes, we see patients in a holistic way, unlike if you on a medical ward it will be oh well you came with chest this person is chest so they like concentrate on that, we do everything we do, we see them, you know we give the holistic care

Yes,

Yes of patients that's what we do on here

So what is this, what is the difference then between you and a physio, or you and an Ot, apart from the uniform

nurses do in control

Erm, like I said the erm, the assessment model is different from what we do erm Physio will not get into feeding a patient, making sure patients sit upright in case they aspirate, we work with speech and language therapist, if you have aspiration pneumonia or at risk of then we make sure you sit up right, if we are not sure and the patient is coughing then we do a referral to them, so we actually are at the centre of looking after the patient, then we use other disciplines in achieving our goals, so that is what we do, I don't know if it makes us in charge or not, but again we are here twenty four hours as well

Do you feel as if you are in charge?

nurses in control

Oh, yes, we have board meetings, Monday is board meeting for all the patients and all the disciplines, doctors physios, you know social workers Ots and that, and I will just stand and you know, lead the team, so I feel yes it is my ward, I know everybody as well, so, I will say yes we are actually in charge nurses yes, because we feedback to doctors, we feedback to other disciplines, and we are here all the time, well not all the time but 24 hours, so in the morning if patient has fallen or high temperature or breathlessness or anything that has happened we feed back to the er occu, to the physio, and to the Ot every morning, so we actually, we do more

role over lcp

Do you think it would be possible, you know if there were, with this client group, you know instead of having a physio and an Ot if you had a generic therapist for rehab, if you had one person

Just er one person to do everything, instead of having Ot and Physio, it is not possible, er I think the role, and, the role of the physio and the Ot they are completely different, er, physiotherapy the assessment is different because, the Ot is sort of similar with what the physiotherapist what they do, but they include cognition and all that which physiotherapists don't concentrate on but is big time for physiotherapists they monitor functional ability of the patient using cognitive, you know if they are confused or impaired or something like that, which I don't normally hear from physiotherapy, the do mention it because they are reading notes and talk to patients but it matters a lot to the OT

R 20/C

Comment [gc16]: The nurses here define themselves as rehab where as the OTs see themselves as acute, the Physios split they recognise that there is an acute ward and a rehab ward and that the nature of the work in the two areas does differ (again it may relate back to where OT has come from if it has come from the community then this environment would be acute)

P. Poppo

Comment [gc17]: Focus, this seems to be key across the professions, their focus is different (leads to the creation of space for negotiation and power differentials)

S/A

Comment [gc18]: Nurses control the access to the patients, or they say they do, but physios see everyone, but they do need a referral on the system, therefore the system is set up to support this restricted access to patients but Physio and OT have adopted different strategies to get around this. This in some way supports the thesis that the organisational goals are dominated by the more prominent professions within the organisation i.e. doctors and nurses.

Comment [gc19]: The nurses are in charge, we use other discipline in achieving our goals, where as the other discipline often view the nursing staff as a barrier to them achieving their goals. It seems to be almost like a Russian doll, there is the over all aim of medically fit then discharge, but then each separate profession has their own specific goals which although will contribute to discharge, are separate and in isolation (Power)

Comment [gc20]: Ownership?

Comment [gc21]: power

Comment [gc22]: power

Comment [gc23]: the importance of nursing and the view of the other professions as doing less....

Yes, OK, I am conscious of time, I have two more quick questions, I don't know if the answers will be quick. With regards to the notion of rehab, er, a number of people that I have spoken to have indicated that because of the pressures of secondary care that the focus isn't on rehab but it is on discharge

Erm, I would not say that because we don't jump straight to discharge, we, we have got processes and things up to a pint but at the MDT we don't actually mention discharge until the patient is stable then other disciplines will mention their concerns and that so it is actually well managed, yes it is not just straight away.

The other question that I have, and again it is around discharge, because of the fear of litigation within, within any organisation, but within the NHS that the micro management discharge could potentially inhibit the patient going home, or could again inhibit rehabilitation because everybody is so focused on safety,,

True, yes, yes we get that a lot when the Doctors have said oh, we are discharging then the Ot who do a comprehensive assessment and who do a beautiful written recommendation and sometimes we in the hospital think, oh well Ot haven't made a recommendation we must not reach that, so people think they must listen to that oh safety that, once we hear safety everybody you know moves back so it becomes so yes,

Is that because you are worried about the patient or is that because you are worried about being sued?

About the patient safety, again both, because if the Ot made a recommendation and said oh well this person or physio it could be a joint decision, oh well walks with a zimmer frame but still unstable or it is something to with kitchen assessment, you know unable to make a cup of tea, and they go home try to hold the frame and try to make cup of tea and they fall then people would think oh well because they didn't listen to what we said, so yes they are scared of, yes, many times you get patients and family shouting at you do it, oh well my mum can't go home because she is not safe, so you get that as well, everything we do will be oh well what will people in the family might, oh well if you do this you might get complaint oh well why did you do that, but is not what we actually think all the time but especially safety, especially falls yes, or someone who you might think that wanders a lot who opens the door in the middle of the night and walks the street, so it is not all patients

Ok, erm last question, this is like the Spanish inquisition isn't it, erm, do you refer all patients to physiotherapy, or do they just see all patients?

Referral

You refer them all

Yes

Do you refer all patients to OT

No , erm, if we feel that Ot needs to see this patient, the decision is made at MDT, otherwise it would be just, sometimes it would be the OT will already know of the patient so then yes,

Comment [gc24]: Nurses view of OT and physio,

Comment [gc25]: Contrast with field notes which appear to contradict this

Comment [gc26]: Rehab can not start until the patient is stable, by which time the medical team want them out, again an example of the priorities of the organisation influencing how the professions operate

Comment [gc27]: Are OTs seen as not being in the hospital?

Comment [gc28]: Priority setting by the professionals and the organisation, see below

Comment [gc29]: See 28

Comment [gc30]: Feeling that every action is open to question by the family (not the patient note), and that this influences decision making

Comment [gc31]: See 30 as an addition, something's they may choose to ignore, but if the issue is about safety then they take it more seriously

Comment [gc32]: Contrast to what the physio's said!

Comment [gc33]: Everybody needs physio, an opinion shared by the nursing staff

Comment [gc34]: Access to patient is limited for the OTs

Ok, I don't think I have any more questions, is there anything else you want to say

No

Ok I will stop the tape

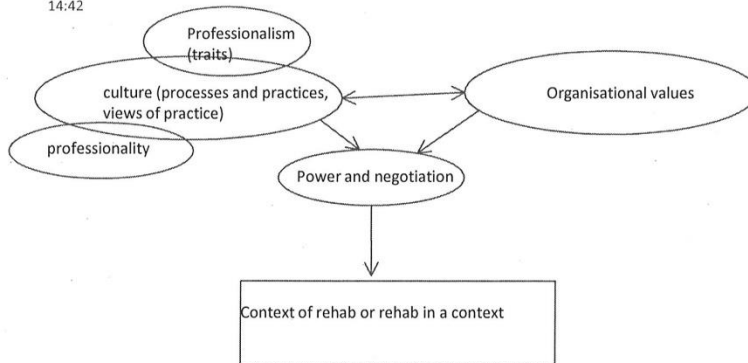
Section three

Section three contains extracts from my research diary directly relating to the analytical process. I chose to record the entire research process in MS OneNote. As a programme OneNote allowed for flexibility and freedom with regards to recording notes and interpretations. This section illustrates directly the interpretative elements of the analysis and shows the development of themes through the modelling of data and interpretations. Through a constant process of comparison and contrasting of the data the emergent patterns and categories forming the case reports were developed.

27/7/11

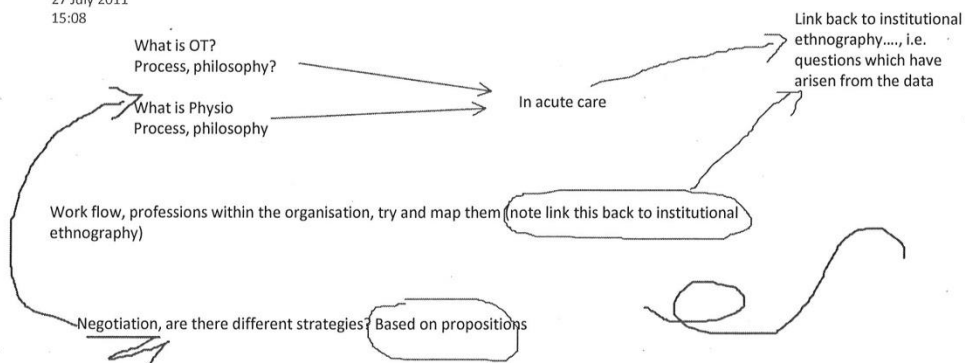
27 July 2011
14:42

First conceptual model elderly NUHT



27/7/11

27 July 2011
15:08



Could look at issues of governance - management => un intentional outcomes

What are the ungovernable dimensions.....

31/8/11

31 August 2011
11:19

Summary of initial ideas

What I did not expect was the relationships between the organisations and the institutions (professions) and how the different professions have adopted their activities in order to fit into the organisation, note contrast OT and Physio, different strategies employed physio aligning with medicine and OT going down the immeasurability route. The impact of the organisation's principles on the professions work, the safe discharge, the nature or view of rehabilitation (note PT 3 gives a great example as to how this has changed over the past 10 years)

What I was looking at i.e. role and identities did not come out that strongly, it is there though and of course linked to what I mentioned above, something that is strong is that all the therapists (I think all I need to look for exceptions) are there for the patients and get a lot of satisfaction from working with the patients (psychology need etc)

7/9/11

07 September 2011
14:53

Thinking on what I was expecting to find (my propositions) and what is emerging from the data, I am aware that I have to be mindful of my potential biases.

My initial research questions and the concepts embedded in them, which I have to say have been developed somewhat with and through engagement with the data as well as with the literature, the three coming together in the processes of analysis, the so call iterative approach, are guiding my analysis and you could therefore argue biasing my analysis? I can see that there is room for criticism here, however, although not overtly, I can perceive how through engagement with the data my conceptualisation of both the initial research propositions and the concepts and theories surrounding these, have changed and evolved in order to on the one hand accommodate the data, but on the other hand been driven by the data for explanation..not sure if this makes sense.

As an example it seems obvious now that the interrelationships between organisation, institution and individual should play a central role in my analysis, and there is some coherence between these abstract sociological concepts and my initial propositions, however, it has only been through engagement with the data and the subsequent questions this raised and the reading that followed that these three analytical concepts became important as a means of explaining my findings.

Is this too simplistic, too soon to latch onto such concepts as a means of bringing closure to what is at this time still only superficial analysis of the data, may be, but it is providing a framework from which further questions can be asked.

7/9/11

07 September 2011
15:05

Organisation => shaping roles and activities there appears to be clear evidence of this

Patient centred practice how is this defined by the individuals..pull all these examples and see what is common and different!!!

Patient centred practice vs organisational needs

(Is this notion of patient centeredness an aspect of professionalism or is it a publically acceptable defence mechanism against the organisation?)

To say that the two i.e. organisation and patient centred practice are in opposition would be too strong, but what seems to be apparent is that what the professions feel the patients need and what the organisation allows the professions to do do not always match up, and here is a point of negotiation.

The obvious question then is how do the professions navigate this?

One example from physio is "I just document it in the notes, or OT we only see those we can help, referrals etc may be?"

Another example of this point of negotiation is between the different institutions, i.e. the semi-professions and medicine, again what the semi-professions think is right for the patient and what medicine feels is the best course of action do not always match up

An interesting point is that the nursing staff view of OT is similar to that of the organisation, so who's views does the organisation reflect? Not AHP????

8/9/11

08 September 2011

10:40

Organisation => roles and boundaries

OT role is a combination of structure and action, note structure is both institutional and organisational, action, individual decisions which going back to the literature is given the term professionalism i.e. how the individual acts in the role of a professional. Note this is key with regards to analysis as it provides a focus to the coding!!

Professionalism therefore encompasses the what people do and how they do it this to a degree being shaped by the institutions and the organisation - structuration theory helps bring these two abstract concepts together

Patient centred practice - what do I mean by this?

Briefly, comparing nursing with the AHPs, there is, or seems to be a schism between care and rehab.

Nurses don't see that there is a problem with discharges, patients sitting around etc because they are safe and they are being cared for, this is their role and therefore they are doing their job. The AHPs on the other hand feel responsible for the discharge of patients and the ongoing rehabilitation and therefore get frustrated with the nurses?

Physiotherapists are running around looking busy seeing everybody, they don't screen, everybody needs physio

OT screen their patients, need referrals etc they are controlling their work flow, but are aware that their primary role is to facilitate a safe discharge, this creates frustration as there is a lack of opportunity for rehabilitation.

There does not appear to be conflict between the AHPs, may be it is because they tolerate each other as they are working toward the same goal, which is getting the patient home.

So who is blocking the aims of the organisation, well from this it would be the nursing staff with their focus on care, but also the AHPs with their emphasis on rehab, if they did not want to try and control their work then the patients would get out faster? May be but thinking about it this argument is a little lame....

8/9/11

08 September 2011
11:01

Patient focused/ patient centred

<Internals\Interviews\elderly\PT elder one 10-11-10> - § 1 reference coded [1.88% Coverage]

Reference 1 - 1.88% Coverage

its not like you need to know loads but you should have like I said an understanding of patients themselves, it comes with practice, when you work in MSk and you come to elderly you know you need to have that patience you know (laughs) because you go bang bang bang and then you come back here and you ask the patient a question and sometimes you have to be really loud, so tis not just you know just talking to them and just off you go you don't cut that relationship do you know what I mean

Yes

So sometimes as I said there could be some vital things, because there, sometimes they do connect with you, than to the other professionals and they would want to tell you something if they are being kind of harassed, or if they are being abused, it could be financial or it could be anything you know, but they would like you to listen to it so you know that's why you need to patience

Is this patient centred practice, how is it being defined here, having a relationship with the patient, understanding them

They connect with you not the other way around, not professionalism as a need, psychological thing

<Internals\Interviews\elderly\PT Elderly 3 (Autosaved)> - § 2 references coded [1.88% Coverage]

Reference 1 - 1.44% Coverage

you know as one patient said to me today because she is going home before, ~~you know we probably would have kept her another week or two~~, she said I quite understand that I'd be better at home, that if I go home I can practice you know from my chair with the rehab team and do everything fitting into her little environment and she was quite happy about that, and she is just beginning to walk, today for the first time to the toilet and she is going home tomorrow. So she is happy, she likes that, so this is the difference I mean, so.

But we can't because she is being discharged?

Reference 2 - 0.44% Coverage

Do you enjoy what you do?

Well it's the patients, its nothing else, I have problems with the nurses and other physios and all that, its just the patients I love.

"I love", this is more the psychology of need?

<Internals\Interviews\elderly\PT elder one 10-11-10> - § 1 reference coded [2.32% Coverage]

Reference 1 - 2.32% Coverage

Er, sometimes you need to prioritise as well when you have a massive case load you know behind you, in one day, and you have this patient you know talking through, sometimes you know obviously you have curtail but again having said that you have to have that sense of, you know what do you call sort of things to really see the patient as needing something if not then you can always stop go and see your priority patients and you can come back to them again, you know, so, but obviously you have to be patient for every single patient you know, sometimes they would like to tell so many things and when you don't get the time when you don't spend the time you'd miss out an important thing as well so its kind of a bit tricky but you have to weigh, and obviously there are other issues like cognition and behaviour, they are demented and alzimers you know there are so many other things that you need to take into consideration so yes, but I would say that you would need you know being patient to assess them, no matter how busy the ward is but obviously you can actually prioritise so.

Physio dealing with a busy ward and how they prioritise patients, does the patient need something not what does the patient want? And it is the professionals view not the patient's, therefore this is not patient centred practice at all...

9/9/11

09 September 2011
11:04

Nursing staff view of OT - rehab vs care

The primary thing here is that the NS see OT as facilitating discharge, this is reflected by OT's who acknowledge that a huge part of their role in this setting is about facilitating a safe discharge, but when asked about the role of OT, OT's see their idealised role as being much broader than this, taking into account things such as functional and cognitive assessments and focusing on improving quality of life. These goals are recognised and are facilitated through the links formed and the referrals made to the community setting, but the actual time spent on rehabilitation by OTs is minimal.

I feel this is important because we have data from one profession indicating their view of the role of another profession which is recognised by that profession, but not in a good way.

The nurses appear to not think that it is a problem that OT's focus on discharge, after all in their eyes it is the OT's role, where as the OTs have an issue with it because it is not really OT work.

Can I theorise this? OT's refer to a culture of discharge, a culture which is at odds with what OTs do as a profession, however, the nursing staff don't seem to recognise that there is a culture divide, therefore we could assume that the nursing staff are part of the dominant culture and OTs are on the outside.

As a concept/theme which could be emerging, the relationship between cultures is apparent, there is no space for rehab, but is that because rehab is defined different by the different professions and therefore in the eyes of the nurses and doctors there is space for rehab because the patients are looked after and get out of hospital, is that not rehabilitation? From the AHP perspective the answer would be no, however do the two primary AHPs regard this in the same way?

The data would suggest not with OTs being on the outside more than the physiotherapists

9/9/11

09 September 2011
11:50

Physio's align with medicine, OT's control their referrals

Profession's influencing their own roles:

There seems to be a number of strategies at play here.

OTs focus on the referral system making sure they do what they want by making sure they get the right patients, or trying to control the patients they get, where as Physio's are seen to align closer to medicine by the nursing staff and themselves, the language they use etc, but there is still an uneasiness with regards to the lack of space for rehabilitation, but it is almost as if they kind of accept it and get on with the more medicalised aspects of their roles, chest suction O2 etc etc

What does this say about the two professions, one has an ideology which fits in with the dominant one of the trust/organisation and therefore can adopt its language, where as the other can not do this and so manipulates the referral system...?

The only way of answering this would be to look at the philosophies of the two professions as indicated by the respondents...a question I have asked before

9/9/11
09 September 2011
11:28

Getting the balance "right"

In who's eyes?

Rehabilitation involves risks, taking chances pushing the patient, there is no space for rehabilitation in the acute setting because the focus is on minimising risks, planning for a safe discharge, tethering a patient to an alarm care for the patient, keep them safe, this appears to be one aspect of the organisation which clearly impacts on the actualisation of the AHP's roles. (note need to contrast this with the observational data which shows that the most dominant institution within the setting i.e. medicine is concerned with getting the patients out of hospital (in this setting i.e. with elderly)

The most obvious thing here is that there is something to balance, care vs rehabilitation?

Do nurses see their role as caring and therapists as not?

Or is it a balance of preferences, those of the dominant institutions and those of the AHPs?
Note I have in the past been talking about the organisation, but is safety and care an organisational preference or is it the remit of the dominant institutions?
The answer may lie in the documentation produced by the organisation...

The nurses view of the physio role is not just walking but chest physio as well, what is not said is the wider role of physio, i.e. rehabilitation, the aim to get the person functionally active this is not picked up by the nursing staff

The nurses role in rehab, that's a one.....what are the twelve processes of nursing rehabilitation?

The Roper-Logan-Thierney Model of Nursing

Posted from
<<http://www.ebsites.com/roper-logan-thierney-model-of-nursing-home/99538/99538>>

The report of what the nurse says she and her staff do with the patient i.e. with regards to rehabilitation is contradictory to what the physio says....

Safety vs risk, rehab vs care
Nursing as an institution appears to have adopted the mantra of care and risk avoidance in contrast to the AHPs, put this in context, the high profile failures and looking at the official line from the RCN the increased focus on risk and risk reduction helps explain this, so why are the AHPs reluctant or wish to get the balance right?

Is it due to the very nature of rehabilitation in that it involves risk taking?

I have talked and the interviewees talk about the philosophy of the organisation, but is it not also the philosophy of the more dominant institutions within that organisation, i.e. nursing and medicine, may be but why do these institutions get privileged in this context (note refer to conversation with Philip about the philosophy @ stanmore or the RNRU for example where AHPs are more dominant - or are they, think about the way people sat @ ward round.....

The Principles

The Principles of Nursing Practice tell us what all people can expect from nursing practice, whether they are colleagues, patients, or the families or carers of patients.

Nursing is provided by nursing staff, including ward managers (in hospitals) or team members (in the community), specialist nurses, community nurses, health visitors, health care assistants or student nurses.

To put it simply, the Principles of Nursing Practice describe what everyone can expect from nursing.

Principle A

Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

Principle B

Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.

Principle C

Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.

Principle D

Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

Principle E

Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.

Principle F

Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.

Principle G

Nurses and nursing staff work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.

Principle H

Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs. Pages for each of the Principles pointing to activities and resources to support their use can be accessed from the left hand menu of this resource. These will be updated to reflect new developments as they occur.

Posted from
<http://www.rcn.org.uk/development/practice/principles/the_principles>

Patient safety



Introduction to the patient safety resource

Patient safety refers to the concept that patients in health care settings are achieving intended outcomes. Keeping patients safe is fundamental to quality nursing care. Principle C of the RCN Principles of Nursing Practice, which describe what everyone can expect from nursing practice, encompasses the safety of all people in

5/10/11

05 October 2011
14:57

I need to go with my gut I think with regards to the analysis, the three main concepts brought out in my transfer doc seem to be appropriate, just need to flesh them out a bit and then move on from there!

29/11/11

29 November 2011
15:25

Physio Acute

Acute don't stay long - seen as a "transit ward"

Assumed, accepted that patients in the hospital in general stay longer in other wards

Rapid, fast decision making

Scope/role, physios notice social issues, pick up where medicine stops with regards to rehab - the rehab agenda

Physio team seen as a team, separate but working along side other teams, closely monitored, informed by and informing the more dominant profession that of medicine

31/1/12

31 January 2012
16:10

I understand now the process of moving back and fourth, or into and out of you data with regards to analysis.

My biggest issue however has been consistency with regards to time dedicated to the analytical process.....

Member check

Initial analysis focused on reading the transcripts and getting a general overview as to what the main categories or issues could be, the result of this was the apparent complex interaction between organisation, institutions and individuals. Note an off shoot of this was a re-reading of Giddens, structure action as a analytical guide.

The next stage was more detailed coding of the transcripts facilitated via Nvivo, this process again was iterative, and created a number of different coding categories, however it allowed me to break the data down into more manageable chunks.

During this process I noticed that I was loosing sight of the meaning embedded in the transcripts, the categorisation process almost become mechanical in nature, I am not saying it was not a useful thing to do but I did seem to be moving away from the data, or the people.

Once I had completed this initial categorisation I then went back to the transcripts in full and re-read them with the initial categories in mind. This re-reading the material allowed me to have a more focused view of the material, it was almost as if I was able to have a conversation with the transcripts, having all the data from a case in my head at one time felt just like a conversation in that it was "well, oh yes PT1 said that but in a different way, or this contradicted what OT 1 said" etc etc. This critical interaction with the data in light of the initial categories helped me form tentative relationships between the categories and begin to develop themes.

Member check

Although fruitful with regards to data reduction and the uncovering of the emergent story of the case I was concerned that this process of "data reduction and thematic development" was again loosing contact with the initial categorisation process. With this in mind I decided to go back to the initial categories and retrace my step so to speak, to check and to tidy the process, to look for areas where I may have say initially considered data to be in one category but then decided to place it in another and to try and explain why I had changed my mind. The constant emersion in the data, the process of moving from the data to the emergent categories and themes helped to clarify and develop the story over all and crystallize the relationships and inter-relationships between the data, categories and themes.

Stage one,
general read
through
Stage two,
identification of
categories, codes
etc, whilst doing
this I reviewed
Giddens re
structure and
action and was
reading
LeCompte and
Schensul as a
guide

Reflexivity
comes in here

Note cross reference this with LeCompte and Schensul

2/2/12

02 February 2012
16:28

1 general read

Cross ref this process with page 85 of LeCompte and Schensul!!!!

2 categories, codes, initial ideas, questions raised from the data etc

3 re-read in light of above, more of a critical conversation with the data, asking questions, looking for relationships generating emergent relationships and themes

4 back to the original categories (stage 2) reviewed codes in light of stage 3, refined themes and categories and relationships, developed thematic map of categories and themes

5 developed explanations in light of the literature theory etc

Initial read and categorisation was influenced by my knowledge of professions etc, however, I tried to allow the categories to emerge from the data as much as possible (inductive analysis), I was ware of this and through reflexivity moved away from this almost formulaic analysis to a re-reading of the original transcripts in full with the notion of simulating a critical conversation with the data (stage 3),

Note to self, codes/categories, relationships, themes in that hierarchy!!

3/2/12

06 February 2012
14:40

Manual coding of stage 3 (see rough)

Team is profession specific = TAPS
Prof perspective/frame of reference = prof per
Rehab in secondary care = R2
AHP MDT working
DC
Role overlap RO
Structure action SA
Power
 Hierarchy PH
 Access PA

Prof view of other Prof = PVP
Safety S
Medical vs social MS
Secondary primary link 2-P
Prof-PT relationship PpT
Context C
Role R

6/2/12

06 February 2012
15:38

Case summary:

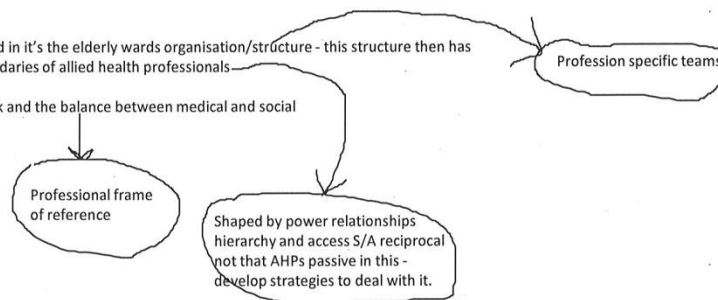
Rehabilitation in secondary care is seen differently by different professions compare NS to OT - the reason for this could be that different professions define and perceive rehabilitation differently
OT - focus on individual
Physio - function
Nurse - maintenance

the professional perspective however do overlap they are defined but also flexible - negotiable within limits

The over all aim of the secondary care organisation is to make people medically better, treatment and discharge (diagnosis and treatment within a medical frame of reference)
Also to ensure the patients safety - minimise risk (note this has issues regarding rehabilitation which is a risky business!)

Aim of rehabilitation is reflected in it's the elderly wards organisation/structure - this structure then has an effect on the roles and boundaries of allied health professionals

Common role of AHPs is the link and the balance between medical and social



6/2/12

06 February 2012
14:44

Elderly NUHT case summary

Rehabilitation in secondary care seen as being different by the different professions (NS, PT, OT), the reason for this is differing professional frames of reference

OT - focus on the individual
Physio Function
Nurse maintenance

The professional perspective however do overlap, roles are defined but are also flexible

The overall aim of secondary care is to make people medically better, treatment and discharge (diagnosis and treatment within a medical frame of reference), another aim is to ensure the patient's safety i.e. minimise risk (note this has issues re rehab as it can be a risky business)

Aim of rehab in secondary care reflected in its organisation/structure - this structure then having an effect on the roles and boundaries of the AHPs

Common role of AHP is secondary-primary link and the balance between medical and social (Prof frame of reference)

Dominant ideology

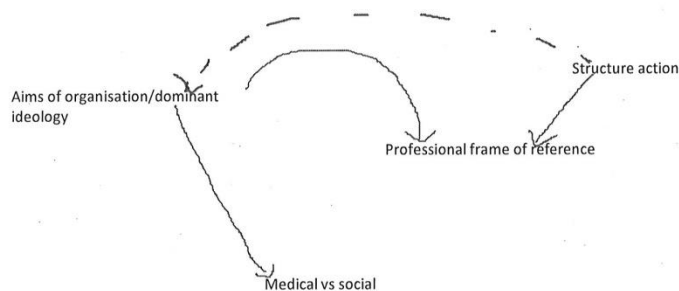
Prof specific teams

Shaped by power relationships hierarchy and access note
Structure Action reciprocal, not that AHPs are passive in this they develop strategies to deal with it

Professional frame of reference with regards to rehab helps to shape the role but this is mediated by the dominant institution (medicine) within the organisation, as well as the overall aim of the organisation itself (the two often reflecting the same thing)

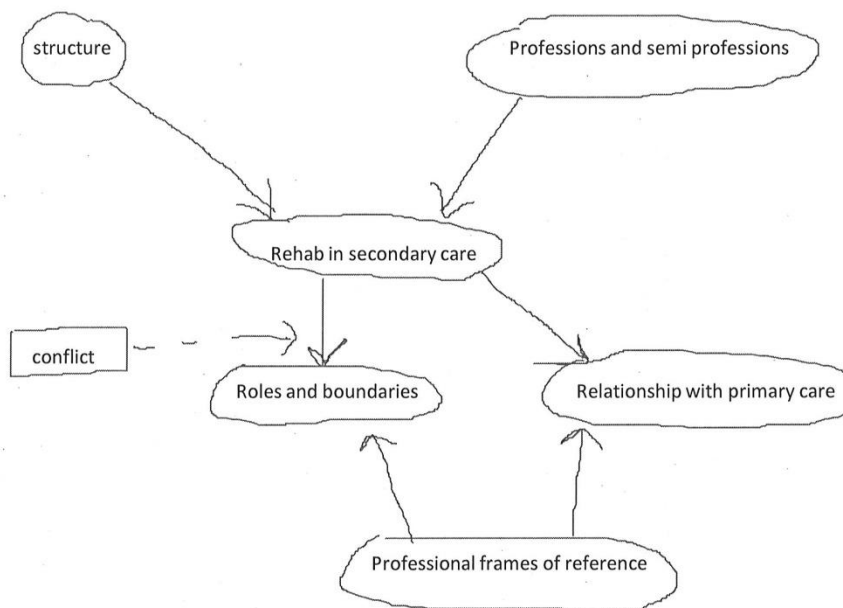
Professional frame of reference is refined by structure action and also redefined by this - professional frame of reference defines roles and boundaries, creates these within the organisation (professional activity), however, as indicated this is mediated by the dominant organisation and institutional ideologies (semi-professions)

What is interesting is that the patient is very quite through-out the whole text, this needs further analysis



7/2/12

07 February 2012
15:49



Professions seem to think that the patients are there for them - this reinforces the view that the NHS is set up for professions not for patients

Note discussion with consultant - secondary care focuses on the short term - but what about long term care who is focusing on this?!!!

8/2/12

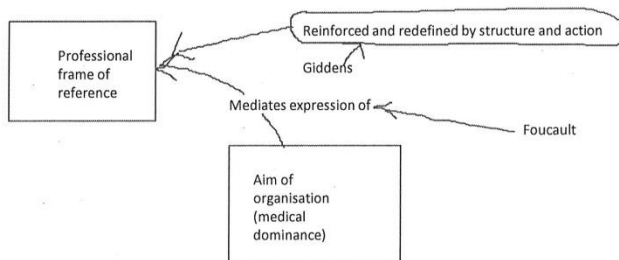
08 February 2012
15:53

Professional frames of reference

Professional frames of reference with regards to rehab => shaping roles but this is mediated by the dominant ideology within the organisation and the over all aim of the organisation (the two reflecting the same thing)

Professional frame of reference is reinforced by structure and action and also redefined by this - professional frame of reference defines roles and boundaries, creates these within the organisation (professional activity), however as indicated this is mediated by the organisation and the dominant ideology (semi professions)

What is interesting is that the patient is very quiet through out the whole text - this needs further analysis but from memory the only time they did come up as when therapists talked about what made their job enjoyable.....



1/3/12

05 March 2012
16:36

I need to distinguish what I mean by structure action!

Some notes on coding (only now!)

A code is a name of a symbol used to represent similar items noted in the data set

Characteristics of nodes:

Operational - code A looks like this

Named - in relation to the concept they describe

Individual codes are distinctly different from one another

Codes attached to primary data normally kept @ a low level of inference (code in vivo)

Later codes have a higher level of inference

Codes - items (low inference)

Categories - patterns (high inference)

Themes - relationships and explanations

(Taken from LeCompt and Schensall)

1/3/12

01 March 2012

16:05

Teams are profession specific (TAPs) - why is this important? Does it relate to structure and action in any way? Structure of the team, how the team is interpreted could go into how the team works - although my data does not support this.

Structure - action

Organisation or the system shaping the role

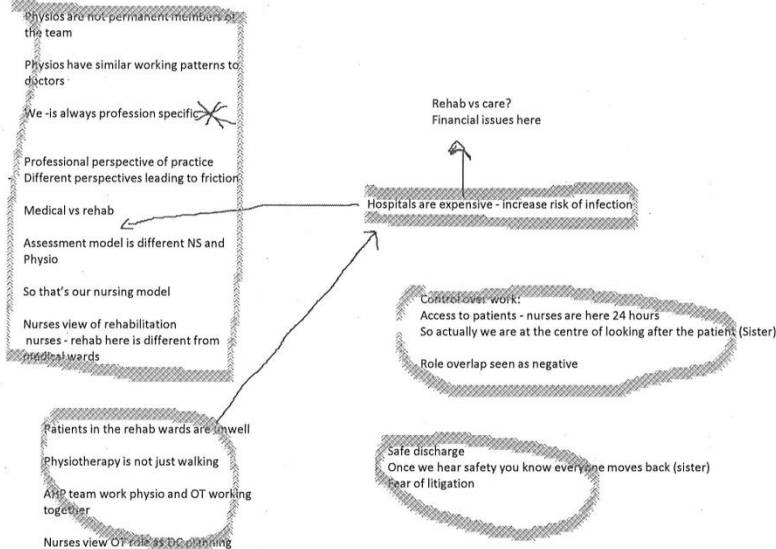
1 - the professions are wedded to certain spaces within the hospital (elderly) but have no control over who comes into this space - although the OTs try and control this via the referral system, physio use a different strategy, but in a way both professions actively seek to influence what they do in light of the restrictions upon them

2 - examples of where the priorities of the organisation subsume that of the professions - safe discharge.

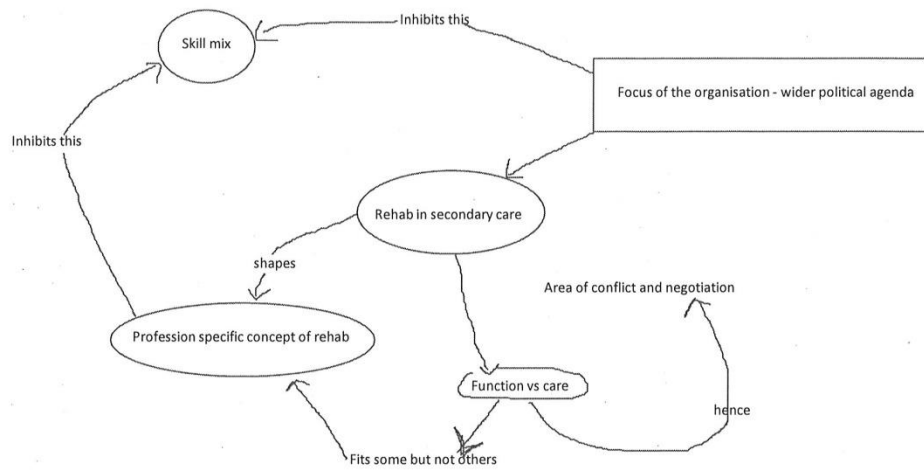
5/3/12

05 March 2012

16:12



6/3/12
06 March 2012
16:23



28 May 2012
14:00

28/5/12

Stage/level 1 codes = low level of inference e.g. code in vivo

Stage/level 2 categories = emergent patterns similar codes inferences regarding preliminary relationships and explanations

Stage/level 3 relationships with possible explanations

Stage/level 4 structural organising relationships into structural patterns this occurred through writing and revisiting the codes

Stage/level 5 theoretical understanding, broader meaning
(LeCompte and Schensul)

Note these
processes occur
through-out the
analytical cycle!

A key element to keep in mind is that words are contextual, the context of the sentence or the context of the interaction, it is important that both are taken in to consideration - however to focus on both simultaneously would mean an analytical framework which is concerned with both semantics and as well as the event (see Miles and Hubberman)

Analysis as a process involves a "systematic inductive thought process that clumps together individual items at the specific level into more abstract statements about the general characteristics of those items as a group" (LeCompte and Schensul, p.68).

With reference to my actual process:

Stage 1 coding reading and re-reading the interview transcripts and observation notes to identify primary codes, conscious effort was made to stay as true to the data as possible e.g. via coding in vivo, however, I was and remain aware that some deductive coding occurs (see LeCompte and Schensul p. 60)

The second stage involved a re-read of the transcripts. Although useful the first stage of identifying codes through NVivo seemed to move me away from what the transcripts were saying, by engaging with the transcripts again I was able to begin to see emergent patterns and contextualise the initial codes, allowing refinement and in some instances re-coding of the data.

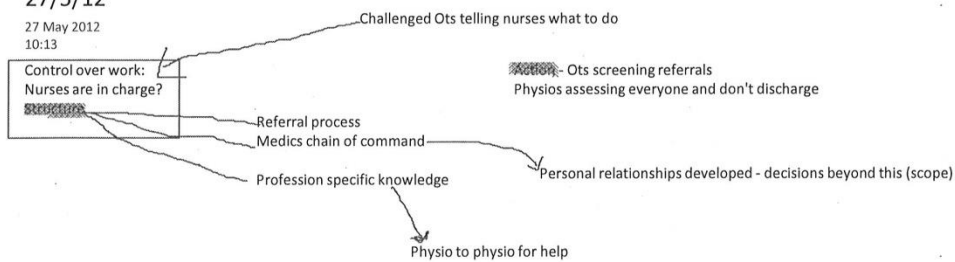
The 3rd stage involved cross referencing the activities of stage one and two looking for consistency and divergence. The codes were made more robust by my attempts to remain true to the transcripts, greater coding in vivo and attention to the context of the quotes (see also Miles and hubberman)

The 4th stage tidying up to create a more coherent picture

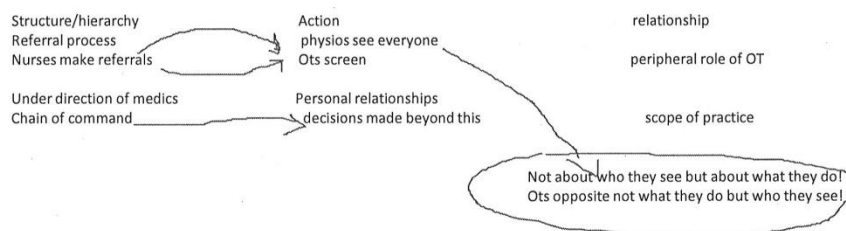
Note the next stage is to move to 2nd order coding i.e. looking for emergent patterns, this has begun and some rough or loose theoretical modelling has begun also.

27/5/12

27 May 2012
10:13



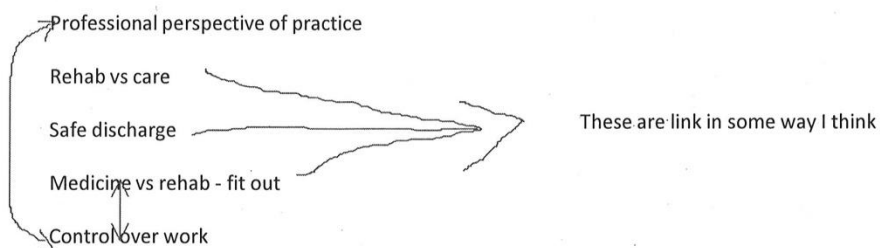
Access and control over work:



28/5/12

28 May 2012
10:38

Discharge vs rehab link



Physios similar to medicine in structure? - no not structure

Physios not the same as nurses - ownership of patient?

Them and us - Identity

Whenever asked about the team we means Ots, nurses Physios etc - indicative of identity, identifying with a group - we, they are the same as me - they are different - seen as different

Physios similar to medicine = see physios have similar working patterns to medicine.

28/5/12

28 May 2012
10:51

Safety - keeping patients in hospital but also limiting what they can do with regards to rehab - it shapes rehab

12/5/12

12 May 2012
10:52

Professions perspective of practice ← Formed by socialisation into the profession and then refined by context of work...?

Not problems but misunderstanding between nurses and physios - lack of understanding of each others roles => conflict - the concept of rehab is different

Assessment is different, focus on the client/framing of the problem.
Also the use of language and meaning eg assistance of one etc means different things to different professions (patient is seen differently) - implications of this with regards to interventions and discharge recommendations

Perspective is shaped by context - Ot changed over time due to working in hospital for so many years - shifted from PCP to facilitating a safe discharge
Physio also indicated perspective shaped by priorities of the hospital

Physios focus on function
Nurses rehab across a spectrum from very ill to doing more, they are involved in everything including mobility but there is conflict with physios - (may be its that nurses are doing everything and they see physios doing a fraction of what they do - they think they physios should be doing more?)

Is this too strong a word - is it mine or theirs?

It is theirs well the physios anyway the nurse used the term misunderstanding - this is key as it indicates the centrality of meaning....

Question - there is an awareness of the differences in perspective - but who's voice is strongest?

Relate also to the pilot interviews

14/6/12

14 June 2012
15:00

Rehab vs care

There is an idea of rehab which is shared by people (not working on the ward but!)
Does rehab happen in the acute setting?
Brought into question by OT, Physio and OT
The focus is on making the patient medically stable and then DC.
The elderly wards are given the title rehab but the AHPs question this "it doesn't feel like a rehab ward to me"
"Well they are called rehab wards"
Why?

NS come into it - attitude - link to professionals perspectives

Staffing - can't see everyone, get to everyone
Complexity of the patients - stay in hospital because of complex needs but then just deteriorate

Dominance of medicine - all the doctors are interested in is when are they going home (Note this links into observation data)

Referral system to OT (link to control over work)

So does rehab occur??
Physios would say yes but, the focus is to get them home, to be functional/stable at the very least to be safe - functioning at a safe level - base line
This however is impacted on negatively by other professionals namely nurses in that they don't carry over - why? - see above

An interesting point raised by one physio was that it has not always been like this - a different concept 10 years ago in the past nurses took the lead on rehab.

So what has changed?
Drs involvement now as patients are unwell - pressures on hospitals, shift to increased community care ← Speculation!!!
But the gap between primary and secondary care is widening?

No its not - a question to ask when I get into primary care!!!

Safe discharge

Pressure to ensure a safe discharge not primarily from professions but fear of litigation, getting a complaint
NS role of physio is to inform the SW re: functional status which then informs the level of care package needed @ DC

But focus on safety means patient stay in hospital and may get worse so why would they do this???

Ots and Physio (more Physio than OT) using safety as a negotiating tool to keep patients from being discharged or to increase the level of care package -

Role of OT in acute setting is to facilitate a safe DC and this is different from their role in the community (check this)

DC seen as a procedural thing, a process that is managed but this takes the patient out of the whole thing - takes the focus away from the person!

The threat of what might happen if risk was not reduced is huge!!!

OT sees it as something directed from the trust not their profession

The process of discharge is to reduce risk - almost an impossible task - consequences are readmission and or complaint both things the trust does not want - Why? → Speculation....

Medicine is not that dominant the AHPs do suggest that their voices are heard but they seem to work around the medics and sometimes against the nurses in order to achieve their goals or modify their goals and their scope of practice not to fit in with the patient but to fit in to the needs of the organisation

AHPs seem to be there to deal with other issues i.e. the non medical and as such find it hard to position themselves within an organisation who's primary role is to treat unwell patients - the role of rehab? - Again this goes back to the spectrum of rehabilitation and the frames of reference of the different professionals involved
Safety is used as a means of keeping people in hospital but this is risky and its about "getting the balance right"

The hospital environment is not designed for rehabilitation....

Control over work:

Physios see everyone admitted onto the wards and don't discharge until they leave the hospital, OTs on the other hand have what seems to be a complicated referral system where patients are screened by the senior OT before they start working with them WHY? This is key I think..

"we have to be very careful about who we are accepting" - OT seems to ration its service, they are selective again why? - staffing, time spent with patients is it that the nature of their role is more time consuming?

Criteria on which patients are accepted by OT is not overt the OTs know what it is but it is not written down..

Note it is acknowledged that this is fairly unique to this trust

Construction of the case
Flesh out roles of OT and PT and NS
Contextualise case i.e. service as a whole and OT and PT service within
Themes and emergent areas of interest focus of the data!

Having criteria made explicit allows for > control over the referral system because the referrals can be challenged based on the criteria - this is not the case in this trust - here the referrals come in via the EPR system (same for physio) and are therefore not screened, therefore the OT have to screen the referral - this takes up a lot of their time, they can not focus on rehab because the rest of their time is spent facilitating safe discharges - but is the hospital setting the place for rehab anyway - the OTs think not

Note in contrast the physios see all patients regardless of whether a referral has been made or not - they are in effect screening all patients and seeing those who they think need physio...

The nurse feels like she is at the centre of everything!!

26/6/12

26 June 2012
13:37

Professional perspective of practice

Acknowledged by all respondents that there is a difference in focus when working with clients
The assessment (focus) is different between NS and PT - clear difference in frame of reference "that's our nursing model" and this has led to "not problems - misunderstandings" however there is evidence to suggest that these misunderstandings persist...

Difference in frame of reference leads to problems with communication - what is meant for example by assistance of one for washing and dressing - means different things to different professions - implications of this are that it may affect patient care with regards to recommendations being made for support post discharge

Shift in focus from PCP to safety and safety @ DC - PCP an aspect promoted at undergraduate level but working in this environment for so many years changes the way the senior OT views her patients - changed her frame of reference away from PCP to safety (professional frame of reference shaped by undergraduate education and the organisation).

Physios focus on function/physical - roles and boundaries cross over between all three professions in that they all deal with physical function - areas of cross over where conflict arises NS and PT meet at manual handling (see prof persp of pract NS elderly) OT and NS cross over at personal care (see prof per of practice OT elderly 1)

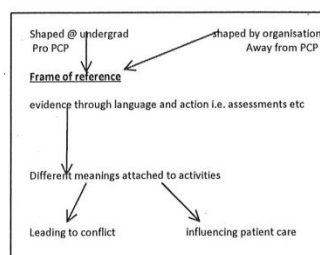
Where tasks are shared get conflict - if this is the case why then is there not conflict between OT and PT (see role overlap the answer might be there - note also not in my data but there is lit regarding this!)

Source - Profession perspectives of practice Nurse elderly)

Source Prof Per of practice OT elderly 1

Source Prof Per of practice OT elderly 1

Wider issue here see 15/11/12!!



Coherent write up
"we" - identity/othering - identifying with - look for negative cases!

Professional frame of reference - defining roles
(are we taking about professional values?)

Distinction between frame of reference and identity viewing identity as psychological where as frame of reference exposed in language and action - why is this not identity...? See Jenkins

Frame of reference - definition of a profession/reflective of fragmentation of tasks - specialisation
Different meanings as a result of - power in language - relate to the use of safety by AHPs in order to gain some control - dominant discourse within certain domains?? Is there a link here to setting/context?

26/6/12

26 June 2012
14:17

Professional frames of reference and hence working patterns are influenced by senior managers

(note which are members of the professions they manage...)
"they just don't seem to have the concept of rehab" (PT elderly 3)
"washing them in bed and just leaving them"

Difference in the frame of reference again affecting patient care
(note it has not always been like this - see previous notes 12/5/12)

With regards to role and boundaries, a key issue to emerge is the meaning of rehab within this setting. NS "enable the patient from when they are very ill....follow 12 processes...if they get better we start sitting them out...." NS elderly

NS see their input as covering all aspects of patient care from ill to becoming independent, they are not reliant on physio but work with them to achieve their (the NS) goals

This issue regarding the meaning and the actualisation of rehab- appears to be key in the interpretation and illumination of AHPs roles in elderly

Linking into control over work i.e. linking to power and legitimacy - NS have a key position in that they see themselves as being at the centre of what goes on with the patient. With regards to OT the NS act as gate keepers to patients through the referral system - the OTs try and mediate against this through the screening process

What is emerging is a complex picture of power relationships between professions - note what is key is that the patient seems to be passive or missing!!

← Almost as if the NS expect this to just happen- the patient is very passive in the process

22/6/12
22 June 2012
11:30

Rehab vs care:

OT question the title rehab ward
PT give examples of where rehab is not happening due to NS

This again comes back to the concept of rehab and what it entails. NS are keeping the patient safe and meeting their needs, but it is not seen by the AHPs as rehab. Just different conceptualisations of rehab or could it be something else?

Not rehab patients are getting worse (OT elderly 2)

Staffing is raised as an issue, but focus also appears to be that the NS don't, in the opinion of the PT engage in rehab the are more concerned with care

Staffing is raised as an issue by both OT and PT and there is a sense that the AHPs are putting the responsibility on to the NS - could the AHPs do more or why don't they - see control over work OT and referral and Physio seeing everyone

DRs pushing for DC - secondary care dominated by this agenda?
The focus of the AHPs is directed toward getting people out of hospital

Recent frontline article - Physio reduced bed days - is this a good thing is this because they force people out of hospitals they are part of this machine - adding to this agenda?

What is the focus of rehab in secondary care? - to get patients well enough "stable" so they can cope at home - not a risk to themselves or others - PT acknowledged that "can't complete it all in hospital but you can stat it here" (PT elderly 3) - there is the assumption then that rehab as a continuum begins in hospital and then continues once the patient is discharged - is this the case???

Are AHPs professions - link to professions within organisations and the concept of semi-professions, although I don't think semi-profession captures it as the AHPs do define and monitor their work practice within their own professional groups etc - but their focus is influenced by the more dominant professions i.e NS and Medics - this is not to say they have no control - see control over work!

There is a feeling amongst the AHPs in elderly that they could do more with the patients - giving a hoist is not rehab but it does mean that the patient can be discharged

The dominance of medicine and the needs of the organisation shaping what the AHPs do!

I feel that I am trying to find cause effect relationships between events - this is not the purpose of the analysis!! I am not positioned to be able to do this - keep to relationships and meaning look at roles and boundaries

Rehab or Dc planning - are they the same?
Rehab does not occur because all the OT time is spent on Dc planning - rehab needs to be picked up in the community (I will need to check this)
Again is it as simple as just the definition of what rehab is?
PT see/feel that they are involved in rehab albeit in a confined arena
NS definitely
OT not at all - but they do get to the patients last (see control over work)

Although given the label rehab both the PT and NS acknowledged that the patients on the rehab ward were generally unwell - this contradicted the Physio from the acute ward who thinks that patients on rehab wards are there exclusively for rehab
The fact that patients are unwell => input from the medical profession, also means that the role of the NS is more like that of any other ward i.e. caring for patients - this combination => legitimises a medical approach to practice
(Why does the acute physio think that patients are there just for rehab?)

Think about his scope of practice and his role...how much does the medical profession actually think about his input - it may be that patients get "more" rehab than on the acute ward - well they do because the primary role of the acute Physio is to treat chests - again the spectrum of rehab - getting more - than what!

PT elderly 2 gives a rationale as to why rehab should be limited in secondary care - the problem, the real issue is in the community, if patients can not cope there then they will just come back into hospital - therefore rehab should be targeted in primary care - this is a strong and simple point - so why do the AHPs i.e the OT have such an issue regarding rehab?? Is it because their roles don't fit there PROR are more primary care orientated?

Relate to professionalism here

Nurses view of rehab "that's a one" (NS elderly)

2/7/12

02 July 2012

11:30

Safe discharge:

A key role of the AHPs is to get people out of hospital, to DC them - what is of interest here and I guess significant is where AHPs fit into this process - central is that DC needs to be safe

Safe a term used to exert power and control - AHPs can use this in order to influence the process of discharge - through their "recommendations" they influence - but reading in to the quote from the NS (safe DC safety as a means of other disciplines NS elderly) it is not a concern for the patient which is driving the process rather a fear of a complaint

The recommendations from the AHPs structured in a formal report goes to influence the level of support the patients gets once discharged this has an influence on resource use - but also serves to protect the secondary care organisation!!

Focus on safe DC, from the OT perspective is different in this setting when she compares to primary care-organisation shaping role?

OT elderly 1 felt that the focus on safe DC was one which was a value to the organisation - a culture of risk reduction, preventing re-admissions to process was not PCP

Safe discharge:

Pressures to ensure a safe discharge not primarily professionally driven, there is an acknowledgement that the fear of getting a complaint from a family member or patient influences decisions regarding discharge planning. "the threat of what might happen if risk was not reduced". Ots suggest that the focus on safety with discharge is something which is coming down from the trust i.e. an organisation priority, not a professional one although safety is important it is just that there is too much emphasis on it.

Ns commented that the role of the Physio is to inform SS about level of function which then influences the care package put in place. Physios (and Ots to a lesser degree) using safety as a negotiating tool to keep patients from being discharged or to increase the level of care package received. This action occurs even when most therapists commented that being in hospital was not good for the patients (see above)

The role of the OT in the acute setting is to facilitate a safe discharge and this is different from their role in primary care

Discharge is seen as a procedural thing, a process that is managed but this takes the patient out of the whole thing takes the focus off the person.

Process of patient care is negotiated and AHPs feel that they have a voice but they seem to work around the Drs and sometimes against the nurses in order to advance their goals, or modify their goals and their scope of practice not to fit the patient but to fit in around the needs of the organisation.

AHPs are there to deal with other issues i.e. non-medical and as such find it hard to position themselves in an organisation who's primary role is to treat unwell patients - the role of rehab? Again goes back to the spectrum of rehab and the frames of reference of the different professions, safety is used as a means of keeping people in but this is risky and its about getting the balance right

Hospital environment is not designed for rehabilitation:

3/7/12

03 July 2012
09:54

Control over work:

Physio's see everyone admitted to the elderly rehab wards and don't DC until they leave hospital, part of the package of care then is physio as standard. NS confirm this and that not all patients are referred to OT

Ots on the other hand have a complicated referral system where patients referred are screened (the referral forms are screened) by an OT before the OT starts working with the patient Why?

"we have to be very careful about who we are accepting". Ots seem to ration themselves with regards to who they see, they are selective why? One possible explanation is the time spent with the patient "carry out a comprehensive assessment" i.e the nature of the role is more time consuming?

The criteria on which patients are accepted by Ot is not overt, Ots know what it is but not shared with other members of the MDT, it is acknowledge that this is fairly unique to this trust. Having criteria made explicit allows for greater control over the referral of system because the referrals can be challenged based on the criteria, this is not the case in this trust - here the referrals come in via EPR (same for physio) and are therefore not screened therefore the OTS have to screen then - this has a negative effect on time they have with patient therefore the focus more on DC than rehab.

Physio's operate a system of blanket referral see all patients on the ward, nurses refer all patients to physio but not to OT. Not everybody needs OT, a view shared by the referrers and the Ots.

Nurse feels as if she is at the centre of everything

3/7/12

03 July 2012
09:57

Medicine vs rehab

Closely related to rehab vs care is the role AHPs play in negotiating for more rehab for patients.

They are concerned with issues which lie outside of the "medical diagnosis" for example social issues or in the case of PT elderly 1 functional issues

The identification of and then responsibility for issues which if not addressed may lead to a failed DC places AHPs in a strong position within the organisation - they have influence over the patients experience and the work of others

In the case of PT elderly 1, he feels he is in a position to determine whether a patient stays in hospital or not, he actualises this by recommending the patients are transferred to a rehab ward. - contrast this with rehab vs care - possible impact of his actions.

There seems to be a tension between the medics and the AHPs around patients being ready to go home - the area for negotiation is at the weekly MDT meetings (see observation notes - however focus was on medical or home not much in between) and the Physios feel they have some say during the decision making process i.e. to keep a patient in hospital HOWEVER the physios acknowledge that by keeping a patient in hospital there is a risk of say HAI, there is also an acceptance that although the immediate time post acute illness is the best time for rehab the risks of being in hospital justifies patients being discharged

9/7/12
09 July 2012
14:44

Professions perspective of practice:

Acknowledged by Physio's nurses and OT's that there is a difference in focus between the professions when working with clients.

The assessment is different between nurses and physiotherapists.

There is a clear difference in the frame of reference "that's our nursing model" and that this has led to "not problems misunderstandings", however there is evidence to suggest that these misunderstandings persist.

"physiotherapists their assessment is different from ours, well we used to have like, I wouldn't say problems, more like misunderstandings, er, nursing staff would think er, if they can't do anything with the patient its physio's responsibility" NS elderly

Differences in frame of reference leads to problems with communication - for example what is meant by assistance of one for washing and dressing, it means difference things to different professions - the implications of this are that it may affect patient care with regards to recommendations being made for support post discharge

Frame of reference - def of a profession, own knowledge base, reflective of fragmentation of tasks and specialisation. Difference meanings as a result of power within language, identification with others through shared language (cross ref with control over work and OT's referral). OT's frame of reference has changed indicating that a) it is not fixed and b) it is influenced by where she works - context shaping practice

"May be, no I guess it, I mean defiantly I will say it has been noted in the past that, I guess the level of assistance, like what I would call minimum assistance compared to moderate assistance compared to maximum assistance, defiantly between Ot and physio but also more between OT and, OT physio as one and nursing staff, so this idea of how much is minimum moderate and maximum, especially I think, its important for us especially when we are looking at making recommendations for care packages and manual handling, erm standards, er," OT elderly 1

Dominant discourse within certain domains of practice - relate also to the use of the word safety by AHPs to exercise some control over what happens to patients

One OT commented that her view of her practice has changed since working in this context. She felt that there had been a move away from PCP to safety and safety at DC. PCP was developed and promoted at undergraduate level but working in this environment for so many years has changed the way she views her patients - changed her frame of reference.

"Umm, well I guess when you're at work its kind of inbuilt as one, yes its something that really, its engrained really so, erm, its just the way that we, we think, and I'm not sure whether its been all these years working in the hospital setting whether tats, that's changed the way I feel about it because that's just the way we work and get used to working get focused, be focused on whether you know when I graduated from university whether that was the focus I don't think it was, the focus was more, on facilitating erm patient centre care and client centred car, erm safety is a part of that, but it's the whole picture from my pint of view, but it is definitely something what I mean is that it is something that is valued, but I don't know whether it is something that should be the main emphasis of acute hospital care and discharges yes," OT elderly 1

Physiotherapists focus on functional/physical roles and boundaries cross over between all three professions with regards to physical function, and it seems that it is where roles cross over conflict arises (is this an issue of jurisdiction/ownership/power) Nursing staff and Physiotherapists meet @ manual handling, OT and nursing staff @ washing and dressing

"If you can not do it on your own then you get help, if two people can't do it then you use the hoist, so that's our nursing model or something, then the physiotherapists their assessment is different from ours, well we used to have like, I wouldn't say problems, more like misunderstandings, er, nursing staff would think er, if they can't do anything with the patient its physio's responsibility but I have so many meetings with the physios and their managers and I related it to the staff at the ward meetings so now it is, we, we work more better, you know within the team, you know they can have, when we have sorted it. Er, the physiotherapists explain that the assessment could be, they could assist the patient from bed to chair then walk them to the toilet and they have done their job (laughs), why the nursing staff, that was before the meeting, they didn't understand that if the physio walked the patient to the toilet they should walk them back until I sorted that out, so they're assessment is that walking the patient to the toilet, its not their responsibility, so yes it is fine, and I have tried to explain this fact to the staff as well at the ward meeting" NS elderly

Where tasks are contested, overlap, no where different professions are involved in the same task there is conflict, the reasoning being that the different professions have differing interpretations of the task and its meaning. Why then is there little evidence of conflict between OT and Physiotherapists? - I think the answer lies in rehab vs care, the definition of rehabilitation, how much this concept is shared between the AHPs and how much it differs from that of the Nursing staff. Another possible explanation could be that the OT's in this case don't feel that they are involved in rehabilitation and therefore don't feel that there is overlap between physios and themselves

"there is this lady I have been seeing for a week, shes going home next week she still had a bed bath today, she has never walked out to the bathroom to wash herself but she is going to have to wash herself when she goes home, oh but I gave her the flannel to wash her face, and I said but that's not helpful now is it when you really think of it, is that helping this person, she has to get out of bed herself and walk out to the bathroom, its, its quite exhausting that part of it Graham, because its almost like, if you don't understand there is a problem, you know I can't solve it for them, you know, but if you just can't see it, you can't help so you sort of have to give up sometimes I think, or go to, it would be better coming from a nurse because we do have a physio nurse thing," Pt edlery 3

Note it has not always been like this - "it was a different concept 10 years ago", in the past nurses did contribute to rehab etc, so what has changed? Drs are involved now (where as in the past the were not, the patients are more unwell and therefore need medical input, this has moved the nursing staff away from rehabilitation towards care (see rehab vs care). There are increasing pressure on hospitals to DC patients and there has over the past 6 years been a move to rehab in primary care but it seems that the gap between primary and secondary care is widening.....

With regards to role

Section four

Section four contains examples of how data was used in the creation of the poly-narrative for the case. The emergent themes were developed and illustrated through direct use of quotation in order to retain fidelity. This analytical process involved the movement from data reduction to interpretation and reconstruction. The examples continued in this section also demonstrate the early formats used in the development of the final case report.

The texts in red are quotes taken from the codes and categories created in NVivo.

The text in italics are the forming interpretations which contributed to the analysis overall.

23/07/2012

Roles and boundaries:

Although often descriptive, when talking about their roles the respondents began to illuminate where their activities intersected with other professions, where boundaries were formed and negotiated and often as a result of this where conflict arose in the form of **power relationships**, more specifically in the negotiation of meaning and language.

What was apparent throughout the data is that the activities in which the respondents engaged were directed toward facilitating a safe discharge from hospital. When talking about their roles the respondents outlined when and how their activities contributed to the overall treatment of the patients in this setting, and in some cases how through this contribution they felt frustrated that in their opinion they were not achieving the most for their patients. What was apparent from all the respondents is that the allied health professionals in this setting felt they were meeting the needs of the organisation and the medical profession but not always those of the patient. Whether they were engaged in the assessment and treatment of patients with acute episodes of illness, or in the facilitation of a **safe discharge**, all respondents felt that their primary goal was to ensure the patients were well enough to be discharged safely.

In engaging with the data there is a clear sense that the role of the allied health professionals in this setting is primarily to ensure the patients are well enough to be discharged. The trust also has a responsibility to ensure that patients are able to cope in the environment to which they are being discharged, and it would appear that it is here that the majority of the work allied health professionals engage in is situated. Another key aspect from the analysis of the data was how the different professions interacted with each other and with patients at different times throughout the process of elderly rehabilitation in secondary care. **The process of elderly rehabilitation** appears to be one of assessment diagnosis, stabilise medically and then prepare for discharge, this final point being where the AHPs appear to be most involved, this being particularly the case for the OTS. What is evident from the data is that time and space for rehabilitation was limited.

Although often describing the same task, for example mobilising a patient, or facilitating washing and dressing, the respondents interpreted these activities differently. Differences in meaning and language were apparent when the respondents were describing their roles and the principle activities they engaged in as part of their roles. A key theme to emerge from the data was the different **professional frames of reference**, and how these helped the respondents make sense of their role within the organisation, but also resulted in misunderstanding and friction between the professions.

All respondents, when talking about their roles made reference to their profession , and the specific contribution their profession makes to achieving the goal of the organisation.

As indicated the professional frame of reference acts as a means for the different professions to position themselves within the organisation, however , their frame of reference is to some degree shaped by the needs of the organisation, with different perspectives being legitimised by the organisation (and the dominant profession) at different times i.e. at different times of the primary process of the organisation (which is to treat patients). These processes are exemplified in the dominant themes to emerge from the data, these being rehabilitation vs care, safe discharge, medicine vs rehabilitation and control over work.

Professional frame of reference:

Starting with the professional frame of reference, as this seems to colour a lot of what the respondents felt about their roles and the roles of others and helped to bring forward a number of the other dominant themes identified.

In talking about their roles all the respondents made reference to their profession and or, accepted models or definitions of practice within their profession.

It was indicated by the Physiotherapists, the nurse and the occupational therapists that there is a difference in focus between the professions when working with clients.

Is this a surprise? A key aspect of any profession is their uniqueness with regards to occupational roles (see Larson etc), and the literature is strong in its identification of profession specific models of practice for the three professions included, although, the paper by ? which looked at OT and Physio may be of interest here.

The fact that the different professions noted that there is a difference in perspective is interesting and can be explained and broadened by current theory and literature. What is of interest however is the emergent consequences of these different perspectives and how they are shaped and go onto shaping the roles and boundaries between the staff (and ultimately the actual and possible implications for patients..!)

It was noted by the ward sister that the assessment of patients, or the focus of the assessment of patients is different between Nurses and Physiotherapists and that this difference has led “in the past” to “misunderstandings” between the two professions, however there is evidence in the data to suggest that these “misunderstandings” persist.

<Internals\\interviews\\elderly\\Nursing staff elderly> - § 1 reference coded [13.04% Coverage]

Reference 1 - 13.04% Coverage

the assessment of patients what we have been trying to sort out, er, between the physio and the nursing staff, erm, we'd go for manual handling and we are supposed to assess our patient and do what exactly what we are supposed to be doing if you assess the load you know you,

Yes the tile thing,

Yes, it all depends on the assessment, if you can not do it on your own then you get help, if two people can't do it then you use the hoist , so that's our nursing model or something, then the physiotherapists their assessment is different from ours, well we used to have like, I wouldn't say problems, more like misunderstandings, er, nursing

staff would think er, if they can't do anything with the patient its physio's responsibility but I have so many meetings with the physios and their managers and I related it to the staff at the ward meetings so now it is, we, we work more better, you know within the team, you know they can have, when we have sorted it. Er, the physiotherapists explain that the assessment could be, they could assist the patient from bed to chair then walk them to the toilet and they have done their job (laughs), why the nursing staff, that was before the meeting, they didn't understand that if the physio walked the patient to the toilet they should walk them back until I sorted that out, so they're assessment is that walking the patient to the toilet, its not their responsibility, so yes it is fine, and I have tried to explain this fact to the staff as well at the ward meeting

What seems to be evident is that the practice of the different professions is influenced by their profession specific models of practice, their profession specific frames of reference. This professional frame of reference also influences how a profession views the work of other professions. *This view of another professionals work seems to be a judgement of that task or activity, the judgement being framed by the individuals professional frame of reference, this action of judging leads to conflict. The question is why should an activity be judged differently, the action of walking a patient to the toilet or washing a patient is a set of procedures, how can it be judged? The answer lies in the meanings attached to specific tasks by the different professions'. What is meant for example by assistance of one for washing and dressing means different things to different professions. One possible implication of this is that patient care may be affected with regards to recommendations being made for support post discharge.*

<Internals\\interviews\\elderly\\OT elder 1> - § 2 references coded [4.82% Coverage]

Reference 1 - 1.90% Coverage

I am just thinking do they do the perspectives of the professions differ that much?

May be, no I guess it, I mean defiantly I will say it has been noted in the past that, I guess the level of assistance, like what I would call minimum assistance compared to moderate assistance compared to maximum assistance, defiantly between Ot and physio but also more between OT and, OT physio as one and nursing staff, so this idea of how much is minimum moderate and maximum, especially I think, its important for us especially when we are looking at making recommendations for care packages and manual handling, erm standards, er,

Implicit within this is the interpretation of meaning attached to a particular activity, the interpretation being shaped by the individual's professional frame of reference – with regards to language use and meaning, an intersecting concept is the dominant discourse (see safe discharge and rehab vs care) and how this is temporal or domain specific with regards to the process of the organisation. What I mean is depending on where the patient is in the process of elderly rehabilitation determines to a degree which profession has dominance, whose discourse has dominance, the shift from medical to AHP, but the window of AHP is so limited and the discourse is shaped by the needs of the organisation anyway (control over work) that it is almost a reaction to the external pressure placed on the AHPS, i.e. justification of their roles through utilisation of the dominant discourse but by doing this they begin to change their practice and thus their frame of reference.

This concept of the process of the organisation seems to be emerging. What I mean by this that the primary aim of the organisation seems to be to admit unwell patients, make them medically stable and then discharge them, however, there is a, albeit reluctant, role in admitting patients that have social issues, although these issues are picked up by the AHPS....(this needs further thought). The process therefore is to admit diagnoses treat and discharge , through this process the priorities move from medical to rehabilitation and here w see a shift in the dominant discourse and the power plays between the professions, although the AHPS, in particular the OTs feel as if they are marginalised the most....Although there is this shift, the AHPS have less time to influence the patient outcome in that they are dependant on the medical profession to make the patient well in order for them to have their maximum effect, however it is at this time that the medical profession wants to discharge them and therefore their focus is directed toward this and away from the patient, i.e. not patient

focused rehabilitation but dominant profession/organisationally driven goals of a safe discharge.

As well as profession specific models of practice influencing how the respondents viewed their work, what was evident from that data was that the context of their work was also an influence. The processes of the organisation influenced how individual professionals viewed their practice and went into shaping their view of their practice. As one senior OT indicated, she felt there had been a shift in her focus away from PCP to safety and safety on discharge. PCP being an ideal promoted at undergraduate level, but working in this environment for so many years had changed the way she viewed her patients, changed her frame of reference.

Reference 5 - 3.74% Coverage

Yes, that's true, yes, I think, well I think the longer you have been in a role then you then you, or a line or failed, you become very, you know, I think you kind of feel like, you know what the focus of the you know what the purpose of your job is, and you know, what, erm, its not like that you master it the longer, well you do I guess you start to master it the longer you go, you can't fully master it all because you've got daily challenges that are very different from the day before or the year before, erm, yes so I feel may be its, its engrained, that becomes stronger as you go through, maybe so much so where you might forget to stop and think, may be like this, Oh is this where we should be going? Or are we just getting carried away with the way it has been the way it is, erm, is this, is this the way it should be? Ummm, Because I think if we were to compare how it was, how it is now to what, all the theory and lovely models and philosophies that we had going through university I think it would be very different given that the resources that we get told about in university aren't actually there in reality! So yes, umm the barriers I guess as well, the pressure for discharge, erm, yes, that's it.

Do you feel as if your, that the priorities are set for you?

Yes I do in a way with the safety on discharge yes, I do kind of feel that, I don't know how, or exactly how or why that, it just feels that that's the culture and it, well it is the culture so..and of course its important erm, because we're trying to erm maximise there safety therefore we don't want them coming back into hospital every two second, and they don't want to be coming back into hospital every two seconds, not everyone chooses to be in hospital so erm, but then I think its being clear, its being clear about just as long as someone knows so the patient knows or the family knows what the risks are and making that decision as to whether they choose to accept that level of risk then we should facilitate around that erm, but then if there is a re-admission then there's this erm, obviously then the case will be brought up again and they will review what happened last time and why did this happen, and, so its kind of, in many ways its kind of a bit paternalistic this idea of, I don't know, making, I think to enjoy life I think there has got to be some element of risk(laughs), risk taking, god, so anyway yes

Yes I'd buy into that philosophy

Yes, so ummm, umm,

Why, why, I kind of get the impression that that sits uncomfortably with you, I'm just intrigued as to why

Oh, sorry say that again

Does that sit uncomfortably with you the fact that

Errrr, not really, no not really, I think that you become so used to working in that, that mind set erm, and because every professional is geared towards that as in looking to that as a goal in this setting, erm, I guess, yes, yes, no it doesn't sit uncomfortably, I just think its, its just something that we'll promote and we'll promote because, not because just we have to but because that's erm a value, professional value, personal value but then I just think that sometimes there is, that there is too much emphasis on it

As already mentioned when talking about their roles the respondents indicated that there were areas where conflict arose, and from the data it seems to be that conflict

arose where there was cross over between the professions. For example all three professions were involved in physical rehabilitation, the Physiotherapists and the nurses cross over re mobilising patients, the nurses and OTs cross over re washing and dressing.

Conflict where roles overlap, where tasks are contested or reinterpreted by the different professions, is this an issue of jurisdiction? If this was the case why then is there not conflict between OT and Physio? One explanation may be that the OTs in this setting don't see themselves being involved in rehabilitation and therefore there is not issue of overlap....

What is apparent is that the different priorities of the professions leads to difference in practice and it would seem that it is the patients that are caught in the middle

<Internals\\interviews\\elderly\\PT Elderly 3 (Autosaved)> - § 4 references coded
[9.20% Coverage]

Reference 1 - 0.39% Coverage

all the patients are seen by the physio and the nurses tend to depend on us a bit too much for erm, waiting for us to sort of get them out of bed

Reference 2 - 2.32% Coverage

You mentioned that you think that the nurses depend on you a bit too much,

They do, its getting, at St Andrew's they, it seems that they, they are not rehab based trained, they are not thinking of rehab they are thinking of acute care, so its a mixture now, at St Andrew's they had to be rehab because they had no night doctors so they had to be medically stable to get there where as here they are sending people from 5 days from the acute ward, so they are still quite acute still quite ill, so they, I know that they are very busy and that they are spending so much time with

the ill people to actually get someone to walk to the toilet to have a shower or a wash in the morning, its easier for them to give a bed bath you know what I mean. Its very time consuming to wait for people to do things for themselves, yes I can see why they don't have the time.

Reference 3 - 2.12% Coverage

there is this lady I have been seeing for a week, shes going home next week she still had a bed bath today, she has never walked out to the bathroom to wash herself but she is going to have to wash herself when she goes home, oh but I gave her the flannel to wash her face, and I said but that's not helpful now is it when you really think of it, is that helping this person, she has to get out of bed herself and walk out to the bathroom, its, its quite exhausting that part of it, because its almost like, if you don't understand there is a problem, you know I can't solve it for them, you know, but if you just can't see it, you can't help so you sort of have to give up sometimes I think, or go to, it would be better coming from a nurse because we do have a physio nurse thing,

Reference 4 - 4.37% Coverage

It could be that it could be that, and that is happening now on our ward, its really heartbreaking to see people in bed tethered to an alarm, can't sit out because , and can we have, for example at the moment there are so many nurses on the ward because we have 3 or 4 students, can someone stay in this bay and see these people sitting in their chairs, do you see what I mean, no we don't have the staff so this person is tethered to the bed until I go and take her for a walk or what ever the person wants to do and then take them, I have to put them back to bed because I am going to leave the bay and tether them to their alarm, so is that helpful ? But as you say its safety

It is you , I want to know what you think

It is a safety thing, its er yesterday I just said to someone I said, because I did ask it again on this particular day, three of the people will always be getting up if you leave them in the chair so I understand you know why it is back to bed, but also I can't figure out when there are so many people around why you are telling me you have no staff, couldn't one person just stay in there for three hours, two hours and at least these people in bed moved, walked and then back in the chair you know, so they can sit up for lunch with somebody always there, its possible because I came up yesterday and I said now if you don't want to do something then you won't do it, it is always possible to do something if you compromise to do it but they said no they don't to do it, I can see that three they want them to stay in bed, but the other three could defiantly be sitting out and eating and.

What appears to be central in this setting is the meaning of the term rehabilitation in this setting and how it is interpreted by the different professions. The nurse interviewed was very "certain" about the nurses role.....

[Internals\\interviews\\elderly\\Nursing staff elderly>](#) - § 1 reference coded [5.83% Coverage]

Reference 1 - 5.83% Coverage

Erm, the nurse's role in rehab, that's a one, we enable patient from when they are not very well, so somebody with pneumonia who can not do a lot, who is very sick, on anti-biotics and erm, so we maintain what we call the activities of the daily living breathing, communication, eating drinking personal care elimination, up to care of the diet so we follow you know those 12 processes, that is what we do, if they get better we could start with sitting them out encouraging them to mobilise, we don't wait actually for physiotherapist always, we just give them breakfast and wait till physio come we carry on doing things and if we can we work together with the physiotherapist

The Nurse saw her input as covering all aspects of patient care from when they are very ill to them becoming more independent, they are not reliant on AHPs but use them to achieve their goals.

This issue re the meaning and then actualisation of rehabilitation within the secondary care setting appears to be key in the interpretation and illumination of AHPs roles and boundaries in elderly rehabilitation.

Linking to control over work, the NS seem to have a key position in that they see themselves as being at the centre of what goes on, and they have a lot of influence over what the other professions are able to achieve (see PT elderly 3 above)(see text rehab nursing also). With regards to OT the nursing staff act as gate keepers = allowing access to patient via the referral system although this is mediated by the OTs by reviewing all referrals. Physio's don't work in this way, they see all patients, why is this? One explanation could be that the Physio's are seen by the NS to be similar to medicine, they assist in the core business of the hospital in that they treat acute conditions and therefore are better positioned to be able to access and bargain with the medical profession as OT elderly 1 commented, the Drs don't know what OTs do...

<Internals\\interviews\\elderly\\OT elder 1> - § 5 references coded [13.27% Coverage]

Reference 1 - 0.79% Coverage

often the doctors really don't know whether or not that patient would be appropriate for OT as well so there is educating, education comes down to not just the nursing staff and the health care assistants and, its also the doctors as well so, yes, it's a rat

What appears to be emerging is a complex picture of the power relationships between the professions, note the patient seems to be absent.

Section five

The final section corresponds directly to the fifth analytical stage described in the methodology. Included are examples of the integration of theoretical interpretations with the case reports. Moving on from this the themes and theoretical interpretations from all four cases were studied together in order to develop the cross case analysis. The table included in this section illustrates an element of this process.

Professional perspectives of practice:

Professional perspectives of practice emerged as a central theme and focuses on how the respondents orientated themselves and their work within the day-to-day of elderly care. Four interrelated subcategories were identified within this theme; these were collective identity, professional frames of reference, judgement and conflict.

A key feature to emerge from the data was how the respondents, when talking about their day-to-day activities, used their profession as a reference point in order to articulate what they did, but also to differentiate their activities from those from other professions. The apparent differentiation between activities along professional boundaries provides some insight into the influence of professional identification on bounding the respondent's work.

Collective identification

An interesting aspect displayed by all respondents was the way in which they described themselves and their team by always making reference to their respective profession. "We" when used to describe a group within the wider health care team always referred to the profession the respondent belonged to, for example we the nurses or we the occupational therapists. Although the three professions included in the study worked with the same clients and on the same wards, it was apparent that they did so as distinct professionally identifiable groups, working alongside one another.

As well as being separate from other professions on their wards; the respondents also distinguished themselves as being specific to elderly. Working with elderly patients was regarded by all respondents as being a specialist area within their own professions and as such required different skills and competencies. This difference in identity from colleagues from the same profession working in other areas was exemplified by the nurse who saw what she did as being quite distinct when compared to colleagues working on general medical wards for example.

Through defining their orientation towards the patients the respondents were able to give meaning to what they did, this process also served as a means of differentiating their work from colleagues from other professions or in other contexts.

The system of patient management

Professional frames of reference:

In talking about their day-to-day activities, all the respondents made reference to their profession through the use of accepted models of practice or definitions from within their profession in order to explain what they did in this context. By doing this the respondents framed their practice and situated it within the overall management of this client group in a way that was unique to their own profession. What was evident however was that the degree to which the three professions felt they “fitted” into the overall management of patients in this context differed, and in the case of the Occupational therapists led to a disjuncture between their professional frames of reference and the roles they occupied.

All respondents acknowledged that there was a clear difference in focus between their professions when working with patients in this context; this was exemplified in their assessment but also in their overall approach to patient care.

The nurse saw her role (and that of her team, i.e. the nurses) as addressing all aspects of the patients’ experience whilst on the ward. Unlike, in her opinion, the Physiotherapists and the Occupational therapists; the nurse saw her role as working with the patient when they were unwell to when they were able to do more for themselves, and justified her work with reference to established models of nursing practice.

Reflexive mediation, context specific the context being the orientation towards a key resource, the patient.

“we enable patient from when they are not very well, so somebody with pneumonia who can not do a lot, who is very sick, on anti-biotic and erm, so we maintain what we call the activities of the daily living breathing, communication, eating drinking personal care elimination, up to care of the diet so we follow you know those 12 processes, that is what we do.” (Ward sister)

Justifying her work in this way helped the nurse anchor her day-to-day as well as distinguish her role from that of other professions.

In a similar fashion, the physiotherapists anchored their day-to-day by framing their work within concepts embedded within their profession. Unlike the nurse, the physiotherapists' focus appeared for the most part, to be more narrowly defined. Although not referring directly to a specific model of practice, all the physiotherapists interviewed defined their work with patients within the context of functional rehabilitation, for example by improving the patients' ability to transfer or mobilise, the aim of which was to reduce risk and facilitate a safe discharge from hospital. The physiotherapists were in agreement that their work reflected the focus of their profession in that they were aiming to help the patients become more functionally independent. They saw their work as addressing the needs of the patient (enhancing independence) and of the wards (facilitating a safe discharge), and that through their input they were able to position their work within the overall management of the patients in this context.

Utilisation of different meaning frames leading to fragmentation in communication

Although acknowledging that their focus was primarily on physical function, the physiotherapists also indicated that a key element of their work, and one which distinguished them from physiotherapists on other wards was the need to address the psycho-social needs of the patients. This more holistic approach was seen by the physiotherapists as the area where they most overlapped with other professions in this context. In light of this, the view held by the nurse that the allied health professionals did not see the patient in a holistic way is challenged and brings into question what is meant by the three professions by holistic care. The nurse defined holistic as being with the patient through out their stay on the ward (from ill to ready for discharge). The physiotherapists by their own admission only worked with patients when the patients were medically stable enough to engage in physical rehabilitation, however, still saw their work as an expression of holistic care in that they acknowledged and incorporated the psycho-social needs of the patient into their patient encounters.

Emergent from the data is that, although utilising the same terminology, the respondents by drawing on different frame of reference interpreted their work and the work of others differently.

The importance of context in shaping the social positions of the respondents. Professional identity is not only a product of the individuals professional frame of reference it is also shaped (and shapes) the context in which it operates. Through mediation individuals attempt to produce synergy between the different meaning frames in operation in order to make sense of what they do. However where the frames of meaning have underlying differences in significance conflict arises reflected in this case by the frustrations felt by the occupational therapists

In contrast to the physiotherapists and the nurse, the occupational therapists found it hard to frame their day-to-day work within their view of occupational therapy. The focus of the occupational therapists' work in this setting was to facilitate a safe discharge primarily through the provision of equipment or the setting up of packages of care, however, this was not congruent with what they had been taught at university, or what they felt was at the heart of occupational therapy.

“if we were to compare how it was, how it is now to what, all the theory and lovely models and philosophies that we had going through university I think it would be very different given that the resources that we get told about in university aren't actually there in reality! So yes, umm the barriers I guess as well, the pressure for discharge.” (Senior OT)

The senior occupational therapist interviewed felt that by working in the hospital setting for an extended period of time that her focus had “shifted” from one which reflected occupational therapy to one which reflected safety and discharge planning. What was clear from all the occupational therapists was a feeling of frustration and a lack of professional fulfilment as they were unable to practice in a way that reflected their profession. The needs of the trust shaped what the occupational therapists did and to some extent their professional frame of reference in a way that, unlike either physiotherapy or nursing, removed them from what they felt was the core of their profession.

Of significance is that in order to give meaning to their day-to-day work the respondents had to be able to produce a synergy between their professional frames of reference and other frames of reference in operation within the context in which

they were working . Break down or conflict in these frames of reference led to frustrations and a lack of professional fulfilment.

Legitimisation of social position by drawing on rules from both profession and the context in which it operates this is brought into question where the synergy cannot be mediated

The respondents, in describing their day-to-day, anchored their work by positioning what they did with reference to its relationship to the needs of the trust and its resemblance to their profession.

In addition, through defining their roles the respondents claimed jurisdiction over certain areas of patient care. For the nurse this was broad, something which their professional frame of reference was able to accommodate. In contrast the allied health professionals had a narrower frame of reference, in the case of physiotherapy it focused on functional ability and for occupational therapy facilitating a safe discharge though the provision of equipment or packages of care.

Role overlap or shared tasks?

Although the respondents were able to distinguish their day-to-day work from colleagues from other profession they all acknowledged that there were elements of their work which overlapped. For example in the case of the nursing staff and the occupational therapists there was overlap with facilitating a patient to wash and dress or ordering equipment at discharge, or across all three professions, with regards to the facilitation of transfers and mobility. Although overlap was apparent distinct roles were created through the interpretation of and meaning attached to the common tasks they performed. This is illustrated by one occupational therapist when describing working on transfers; she explained that even though she may be doing the same task as a physiotherapist the focus of the two professions and the meaning attached to the activities differed significantly.

Through the claiming of jurisdiction based on professional frames of reference (knowledge and skills) the respondents were taking on obligations and sanctions

associated with these however where these were not being fulfilled it resulted in conflict

“we have different heads on when we’re doing it I suppose, I always have the head on of what will they need post discharge to be able to achieve what they have just shown me, were as a physio would probably, I mean I don’t want to jump the gun, but probably would have stopped and think they can do that here and now that is enough from my perspective, tick yes, where as I suppose with an OT head on you, you think right they can do that but can they do that out of this setting,” OT 2

Implications of differences in focus and as a result meaning attached to activities, between the professions were seen in the level of supported provided by the different profession to patients whilst on the wards. Which tasks were emphasised and which were neglected, and how these tasks were interpreted was a direct reflection of the respondents’ professional frames of reference. These interpretations also extended beyond the ward. Depending on whether or not a patient had had input from the AHP teams determined to a degree the recommendations made at discharge planning meetings and the subsequent support offered to patients once discharged. Such variations would not in principle matter if all patients received AHP input, however what is evident from subsequent themes and the process of care described previously this was not the case.

The meanings, the interpretations of the tasks performed by the different professions with patients were a product of their individual professional frames of reference. It was through these interpretations that roles were defined and distinguished.

Purpose vs act a key element in Giddens’s concept of reflexive agency. Although the acts are the same the meaning/purpose attached to them differ an artefact of professional frame of reference.

Differences in meaning leading to conflict between the professions:

The importance of these different interpretations of commonly performed tasks become apparent in their production of barriers to, and conflict between the

professions. The differences identified in the respondents' professional frames of reference led to problems with communication between the professions. Tasks were interpreted in light of the respondents' professional frames of reference. So, for example, the Physiotherapists placed more emphasis on the patients' ability to transfer out of bed independently whereas the occupational therapists facilitating the same task placed emphasis on how the patient would cope once discharged in performing this activity. Similarly, in describing the assessment of a patient's ability to wash and dress, one occupational therapist commented that a nurses interpretation of needing assistance to wash differed considerably from that of an occupational therapist . The result of which meant that the occupational therapist may provide less assistance where as the nurse may provide more.

“nursing staff saying oh yep they need assistance with washing and dressing ok, and we would be like ok is that assistance of one person or is it assistance of two people, oh yes assistance of one, is that quite a lot assistance are you getting, are you using quite a lot of your energy, or erm, is it just a little bit, a little bit of fine prompting or physical cueing or is setup, is just setting up the environment, set up assistance without any physical contact or, is it verbal prompting or yes, just really kind of establishing how much hands on assistance is required or, is it something that you need, you need to assist the patient in initiating and then they can then complete it...(OT elderly 1)

The delineation of tasks along both professional and organisational frames of reference allowed the respondents to position their work and distinguish it from others. However in doing this they made claim to specific aspects of the system of care. Breakdowns in perceived obligations attached to these claims led to conflict

Sharing of power inherent in the adoption of social roles the normative obligations and sanctions attached where, through a conflict in meaning frames this is fragmented then a breakdown in communication and conflict emerges

These differences in focus and meaning between the professions may be responsible for the respondents' candid reports of conflicts between the professions working in this context. Although as indicated there was some overlapping of tasks,

the delineation of roles through the use of professional frames of reference led to the formation of boundaries and in some instances conflict between the professions. This is exemplified in the task of transferring a patient out of bed. Although the nursing staff engaged in this task, they viewed it as being the role of the physiotherapist and as a result expected the physiotherapists to engage patients in this task regularly.. In contrast the physiotherapists saw their role as assessing the patients' ability to transfer out of bed and then to provide exercise to enhance this. Thus although the task was similar through the differing meanings attached to the task, roles were created and boundaries drawn.

“physiotherapists their assessment is different from ours, well we used to have like, I wouldn't say problems, more like misunderstandings, er, nursing staff would think er, if they can't do anything with the patient its physio's responsibility” (ward sister)

“all the patients are seen by the physio and the nurses tend to depend on us a bit too much for erm, waiting for us to sort of get them out of bed”(PT elderly 3)

A focus on care and a lack of rehabilitation

It was clear through out the data that there was greater emphasis on caring for patients as opposed to rehabilitating them. Although there were designated wards for acute admissions and rehabilitation, the rehabilitation wards served primarily as an overflow for the acute elderly ward, admitting patients who were often acutely unwell or whose discharge had been delayed due to complex social issues.

The power exerted by the patients, but not as individuals but as through their status as patients – power in the sense that they can to a degree determine what the allied health professionals do
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“often erm the patients who are on the rehab wards aren't actually appropriate for rehab in the first place because they're being sent there as a, to wait for their, to wait

for a nursing home placement or to wait for a transfer to another hospital or something, so its really just another use of a bed” (Senior OT)

The often complex medical needs of the patients on the rehabilitation wards legitimatised the need for ongoing medical and nursing care.

“they are sending people from 5 days from the acute ward, so they are still quite acute still quite ill, so they, I know that they are very busy and that they are spending so much time with the ill people to actually get someone to walk to the toilet to have a shower or a wash in the morning, its easier for them to give a bed bath you know what I mean. Its very time consuming to wait for people to do things for themselves, yes I can see why they don’t have the time.” PT elderly 3

A consequence of this was that although these patients had been identified as having rehabilitation needs the work of the allied health professionals mirrored that of their colleagues on the acute ward, their focus being on addressing the acute medical needs of these clients and facilitating a safe discharge.

Focus of work legitimised due to the needs of the patients, however, this need was determined not by the allied health professionals but by the nurses. It also placed the nurses in a position of power over the allied health professions – see later key issues here are the legitimisation of medical care due to the status of the resource i.e. the patients.

The allied health professionals felt that a lack of rehabilitation and the privileging of care in this context often meant that patients deteriorated as opposed to improved. As one OT suggested, by prolonging the care of patients they became less able to do things for themselves. The occupational therapists in particular stressed that their work in this context involved little if any rehabilitation, their primary and often sole focus was to facilitate a safe discharge for the patients.

“in this acute setting it is, erm facilitating a safe discharge, but there is this idea of this rehab ward and so often we get a referral for a patient who is going home in the next or there is a discharge set for planned for the next couple of days and so between the time of referral and the time they go home there is absolutely no rehab

that goes on in that time because the discharge planning takes up all of that time, er, so yes it ends up being, in an acute setting facilitating a safe discharge, umm, and with referral onto service which can carry out the rehab in the patient's own home or where ever it may be" (Senior OT)

By drawing on rules and resources beyond their immediate professional frames of reference (significance of community based rehab and the risks associated with hospitals) the respondents were able to reconcile and give meaning to what they did in this context. Roles thus shaped by both the professional and the context (additional rules and resources available to them- note rules and resources being both restrictive and enabling)

Through the legitimating care over rehabilitation the allied health professionals reinforced the ethos of the trust i.e. one which is focused on care the duality of structure

Although the physiotherapists echoed this view, when questioned directly if their role was to engage patients in rehabilitation both physiotherapists who worked on the rehabilitation wards argued strongly that rehabilitation was a central part of what they did. This seemingly contradictory response could be explained by the physiotherapists' conceptualisation of rehabilitation. They viewed rehabilitation on a spectrum of functional activities, they valued their input in that it meant that patients would be able to function at a safe, but basic, level once discharged. However, they **acknowledged** that the process of rehabilitation was something that needed to continue once the patients were in the community setting. The lack of opportunity to engage patients in prolonged rehabilitation beyond that of being safe for discharge led both groups of allied health professionals to place emphasis on the need for rehabilitation to continue or in the case of occupational therapy begin in Primary Care. In doing so the allied health professionals were able to reconcile the potential conflict between their professional frames of reference and the context in which these were being utilised. This process of reconciliation was further evidenced by the allied health professionals suggesting that hospitals were not the best place for rehab

Issues such as a lack of time and resources to effectively engage patients in rehabilitation, in addition to the recognition of the pressures on beds and the risks of

prolonged hospital stays were cited by the allied health professionals as a means of supporting the need to discharge patients rapidly.

What is apparent is that the primary focus of secondary care was to manage patients medically and care for them until they were well enough to be discharged. The ethos of the organisation was reflected in the work of both the nurses and the allied health professionals. One of the respondents, a physiotherapist, who had been working in the NHS for over 30 years offered an interesting insight into how the focus of secondary care had changed in the past 10 years. In the past patients admitted onto rehabilitation wards were there exclusively for rehabilitation. Rehabilitation wards rarely had medical cover, the wards were nurse led and so the patients had to be medically stable before being transferred there.

Reflected in this insight is how changes in the direction of services has had an impact on the work of the allied health professionals and the nurses in this context. The move toward hospitals being primarily focused on the medical needs of patients has resulted in a reframing of the work undertaken by staff, in particular the allied health professionals.

Highlighting the relationship between changes at a service level having an effect at the level of roles and boundaries and identity. The link between meso and micro and how through mediation the respondents are able to reconcile this within their professional frames of reference.
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Control over work:

What is clear from the data is that in this context the medical needs of patients took priority. Once the patients' medical conditions had been addressed then the whole process of input moved to discharging the patient as rapidly as possible from the hospital.

Knowledge of and control over the medical needs of the patients placed those professions with these facilities within a position of power

What was clear from the MDT meetings and from the narratives of the respondents was that discharging patients was central to the work of the whole multidisciplinary team. The dominance of the medical profession in this process was clear. As soon as a patient was admitted onto the wards the first thing to be planned was the predicted discharge date. This date centred on the estimations made by the medical team regarding the likely time needed for the patient to recover medically. This date also bound the work of the allied health professionals by placing a time frame in which they could complete their tasks of helping the patient to be as functional as possible. However, it was not until patients were medically stable that patients could engage in rehabilitation and as a result the focus of the allied health professionals work centred around ensuring that patients were safe for discharge.

The creation of space in which to actualise roles determined by the medical profession. A reflection of the power of medicine i.e. restricting the agentic capacity of the allied health professionals through limiting the time in which they have to work. Through controlling a key resource i.e. the patient the medical profession could exert a degree of control over what the semi-professions did

“I think as soon as, as soon as the doctors say that somebody’s medically fit and they want them home if they’re needing assistance of two then its a manual handling risk so they need a hoist, but they might not need assistance of two, most of the time they might need assistance of one but occasionally they might need assistance of two but, its always like that’s the sort of quick option, you know that’s the safest thing the careers have got the hoist and that’s it and I think social workers are a bit like that as well “ (Junior OT)

Although the discharge date was determined largely by the medical profession, the allied health professionals, through their focus on a safe discharge were in a position

to influence the decision making processes of the doctors. Through the discourse of safety, the allied health professionals could influence and in some cases determine the length of stay of patients on their wards, or the level of support patients received once discharged.

Through drawing on the discourse of safety the allied health professionals were utilising the rules of the organisation in order to mediate their work and exercise a degree of power over what happened to the patients – creative mediation

In addition to the discourse of safety another means by which the allied health professionals sort to exert a degree of control over their work was by rationing their services..

It was clear from the nurse interviewed that she regarded the nursing team as being at the centre of what was going on on the wards. Nurses were with the patients twenty four hours a day and as such had access to their day-to-day lives within this context. The nurse said that due to this proximity the nurses were in a position to control what happened to the patients.

Through their proximity the nurses had control over the key resource the patient. This control was manifested in their knowledge of the patients this knowledge gives them the facilities to exert power, i.e. control what happens to the patients

This control extended to determining whether the patients were seen by the allied health professionals or not. This control was structured through a formal referral system Patients requiring allied health professional input needed to be referred by either the doctors or the nurses. The referral system was linked to the allied health professionals' activity monitoring and so was used to determine the yearly budgets and staffing levels for the allied health professional teams.. Through this formal system of referral the nurses and the medical team were in an apparent position of power as they could in effect determine who was or who was not seen by the allied health professionals.

Two of the physiotherapists interviewed said that they assessed all new patients who came onto the wards regardless of whether a referral had been made or not. The rationale for this was provided by one of the senior physiotherapists as:

“Just about everybody needs, there are very few that come I can say you know are up walking, good balance and they don’t need anything” (PT elderly3)

The physiotherapists team chose who they saw depending on the outcomes of their assessments. However, the physiotherapists were aware of the implications of not having a formal referral in place. As a result the physiotherapists instructed the nurses to refer patients if, after their assessment they thought they needed physiotherapy input. In addition to this, by having assessed all patients, they physiotherapists had a good knowledge of who was on the wards and used this during the formal ward meetings as a means of contributing or not to the formal discussions thus embedding themselves within the team.

Through gaining knowledge of the patients the physiotherapist had the facilities to exercise more power within the team

In contrast to the physiotherapists, the occupational therapists only assessed patients that had been referred to them. The occupational therapists, acknowledged that not all patients on the wards would need occupational therapy input, and so by utilising the formal referral system in order to access patients they were in a position to limit the number of patients they saw. In addition to this the senior occupational therapist screened all the referrals before accepting them, again as a means of controlling who her team accepted.

Mediation through the additional screening process due to limited resources the OTs rationed what they did. The physiotherapists were in a similar situation but they chose to see all and then ration – both professions in effect rationed what they did!

the senior OT said that she had to be “very careful” as to whom she accepted onto the teams’ case load, as occupational therapy input was in her view very labour intensive and she had limited resources. Through this screening mechanism the occupational therapy team were in a position to ration their services. However, by only seeing patients referred to them and not screening all patients admitted onto the ward, the Occupational therapy team had a list of patients waiting to receive their service, one outcome of this was that an aspect of the senior Occupational therapist’s role involved screening and managing the waiting list.

Unlike the physiotherapists who had contact with all patients on the ward, albeit in some cases limited, the occupational therapists only knew of those patients who had been referred to them. A consequence of this was that during the formal ward meetings the occupational therapists were often unaware of whether a patient needed their input or not and so were unable to contribute fully to the patient discussions. A more significant impact of the reliance on other professions for accessing patients was that the occupational therapists often only received referrals once a patient was ready to be discharged and as a result had only a limited amount, the focus of their work therefore being directed away from rehabilitation toward facilitating a safe discharge.

Cross case analysis

Themes	Key points	Interpretations	Key concepts
Professional frame of reference	<p>Collective identity, elements of othering</p> <p>giving meaning to work through framing it within profession and the organisation</p> <p>OT at odds disjunction between profession and their practice in organisation</p>	<p>Creation of social positions within the organisation</p> <p>Importance of professional frame of reference to give meaning to practice, but does not operate in isolation, needs to fit within the organisation as well – underlining the importance of context (this is my proposition)</p>	<p>Use of organisational and institutional rules in order to give meaning to practice to legitimise what they did</p> <p>Knowledgeability of agents</p> <p>Reflexivity of agents interpretation of both</p>

		Where it does not fit leads to frustrations - conflict in frames of meaning	institutional and organisational rules
Role overlap	<p>Shared tasks</p> <p>Examples of professional frames of reference in action</p>	<p>Purpose not act</p> <p>An example of professional frame of reference important with regards to skill mix etc</p>	<p>Institutions/professions framing what is significant in the respondents' work – signification</p> <p>Knowledgeability of agents</p>
Conflict	<p>Expectations of others</p> <p>Examples of professional frames of reference in action</p> <p>Extended beyond the day-to-day</p>	<p>Jurisdictions</p> <p>formation of social positions and obligations attached to these</p> <p>An example of professional frame of reference, what is</p>	<p>How meaning frames structure both what is significant and what is legitimate</p> <p>Conflict of interests</p>

		<p>accepted and what is not where value is placed</p> <p>Temporal element to the work although operating in this context influences other contexts</p>	
Focus on care not rehabilitation (Exemplified by safe discharge and control over work)	Unwell patients meaning care was priority	<p>Power of patients determining what people do – but patients not as individuals, patients as unwell – once well no longer of interest in this context therefore patients seen as a resource defined by the medical profession as such – patients only have authority via their diagnosis</p>	<p>Structures influencing meaning frames of respondents</p> <p>Legitimizing of care through control of resources by organisation and dominant profession – power and authority</p>

	Change in ethos of secondary care	<p>Meaning frames dominance of medicine – the knowledge the medics have over the patients condition gives them the facilities to exert control over the other professions</p> <p>Organisation and medicine legitimating what can and not be done through control of resources both physical and mental/moral wider link to macro structures i.e. policy</p> <p>Mediation by the respondents in order to reconcile this i.e emphasis on primary care – or not in the case of the OTs leading to frustration –</p>	<p>Strong structure weak agency</p> <p>Structure shaping meaning frames but this is interpreted and reconciled by the respondents (agency)</p>
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	<p>How rehabilitation was defined</p> <p>Emphasis now in primary care</p> <p>Changes in professionals outlook</p>	<p>refinement of meaning frames in response to structures i.e. significance of medical status legitimated change in approach to rehabilitation</p>	
Safe discharge	<p>Dominance of medicine in defining when a patient should go</p> <p>Safety as a priority fear of failed discharge or complaint</p>	<p>Power of medicine exercised through the control of resources (patients) influencing what AHPS do</p> <p>A reflection of the interests of the respondents they were able to recognise and reconcile this – a contradiction to the external view of</p>	<p>Domination</p> <p>Legitimizing – the question here is one of morals through legitimating the focus on safe discharge the respondents are having to forgo elements of</p>

		<p>professions, however, unearths deeper more cynical view of professions as self protective (Larson etc)</p> <p>Utilisation of the discourse of safety as a resource in order to exert control</p>	<p>their professional frames of reference and privilege other aspects physiotherapists reconciled this by placing emphasis on primary care, occupational therapists were less able to do this – WHY?</p> <p>Mediation- creative agency</p>
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	<p>Safety as a bargaining tool AHPs able to influence decision making</p>	<p>safety as an authority in order to legitimate their actions in the trust – (link back to professional frame of reference and use of resources in order to anchor practice within the organisation)</p>	<p>drawing on organisational rules in order to position professions. But is there a compromise (see above with regards to legitimating)</p>
Control over work	<p>Note the last point is an example of one way the respondents exerted control over what they did</p> <p>Accessing patients Different routes used in order to gain access to patients</p>	<p>Control over resources within the organisation – patients are a key resources but not them – what is known about them.</p>	<p>Utilisation of resources</p>

	OTs self as resource	<p>Nurses report control via proximity provide them with access to knowledge about the resource thus they have the facilities to exert power</p> <p>Physiotherapists screen all patients in order to have a similar degree of knowledge as the patients – to be used as above in safe discharge</p> <p>OTs recognised that they were short staffed and therefore used themselves as a resource – by restricting what they did they could control it, however, it had a negative</p>	<p>Knowledge – facilities- power</p> <p>Active agency creative mediation use of resources in order to influence structure</p>
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		<p>impact in that it marginalised them – was this their intention?</p>	<p>Active agency, use of own knowledge as a resource legitimated by own morals but not those of the organisation.....?</p> <p>Unintentional outcome?</p>
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Appendix B

Reflexivity:

A central element running throughout the research process is the importance placed on reflexivity.

This section contains examples from my research diary which illustrate how reflexivity permeated thought the project.

The first section provides an example of a reflection on being in the field and draws attention to ethical considerations connected to field work

The second section contains examples of my reflections on the research process these include both data generation and analysis.

The final section contains examples of how through reflexive writing the methodology was developed.

Section one:

Field work

16/12/11

16 December 2011
16:30

On one rare occasion when I was on the ward, waiting for an MDT meeting to begin, I was standing in the corridor not far from the nursing station, just by the entrance to one of the side room. While I was stood there I could hear a patient in one of the side rooms' call for a nurse, then for any one, to help him. Although there were a number of ward staff passing the side room, no one stopped to see what the patient wanted. This went on for a number of minutes, the patient becoming more agitated, (raised voice, pleading for help) I decided to go and ask the patient what was wrong. As a physiotherapist who has had 10 years working in in-patient rehabilitation, I did not question my decision with regards to my competence to be able to deal with the situation, however, I was mindful of my status on the ward, as a visitor, as a researcher, and was acutely aware of the possible consequence of my decision. When I entered to the side room, the patient, an elderly man, was sitting on the edge of his bed. On seeing me he said "thank god, all I want is for someone to go and get me a news paper" and he offered me the correct change. I explained to the patient who I was and that I did not work here, but said that I would be more than happy to go to the shop and get a paper, which I did. On my return the patient, engaged me in conversation, explaining that no one listen to him and that he was board just sitting here in hospital, I was pleasant back, but did not stay long as the meeting I was scheduled to attend was about to start. Once I had left the patient I found the ward sister and told her what I had done, she seemed disinterested.

My involvement in the environment
note also use the inserts to illustrate
what I am saying with regards to the
data etc

being on the ward was no an uncomfortable
experience for me, however, not being part of the
wards was. I was aware of my presence being
acknowledged but also being ignored. The ward is
neither a public or a private space, it spans the two.

Section two:

The research process

analysis

06 July 2011
15:58

Thought I was going mad so had a quick chat with Jacqui re: analysis

Working on the first case study, using Nvivo to help with the analysis. Going through line by line I just seem to be generating more and more nodes, one interview generated 30+ categories, and I still feel that this is not enough or too much. I was and still am a little concerned that I was losing sight of the original research question.

One of the memos I created is about the research question, an attempt to ground myself, keep focus. Writing the memo though felt like over simplifying what the data holds, to focus just on roles, boundaries and identities as defined from the literature I have accessed, I feel, is restricting what the participants are saying, however letting the "data talk" is just giving me multiple categories, which when taken out of context are often meaningless, or that are too similar that they should be one category but not...

Jacqui has helped clarify a few issues and given me a little more of an idea of where I am going (I am not just wasting time, although this is part of the process apparently...)

Line for line analysis is important but I should (and have already) start to notice themes developing. In truth this process started with the actual interviews and is reflected in the types of questions I was asking participants as well as on the style of the interviews as a whole. This emergent analytical frame has been enhanced and developed through my transcription of the interviews, although not formally, I was, on reflection, aware of the common themes running through the participants answers. To be open, my questioning was influenced in part by my reading but more so I would say by the data gained from previous interviews.

The development of themes linked back to the line by line analysis and related to my reading is in Jacqui's view the first stage of the analytical process (note this could be a single chapter in the final thesis). Stage two would involve looking for (an active process...) relationships between the themes and their relationship to theory. A theory sandwich Jacqui called it, whereby you start with a thin slice of theory, have a filling of data (practice, real life) and then have a different slice of theory based on the previous two as well as your analysis.

We discussed early themes, the nature of rehab in secondary care and the focus on safety (protectionism) being the two most prominent for me.

We also discussed my initial research question, had it changed, may be not, the roles described in the data are not what I expected in terms of a physio doing an OT's job etc (note thinking back to the formulation of the research question, the influencing factors such as common learning, the generic professional etc heavily influenced my initial propositions), the roles of the professionals interviews are shaped by a number of factors, but there is commonality in that there is a sense of rehabilitation and patient centeredness, and to be honest so far it seems quite clear and the participants are quite comfortable with what they do. The roles seem to be shaped or influenced however, by the organisation, the philosophy of the acute hospital, the relationship between rehabilitation and secondary care as an organisation and an institution (i.e. medically and management dominated) is a theme which appears to be strong, here is the point of negotiation, of power struggles, dominant discourse and structure and agency.

I can see how through analysis both the research questions and the data gained are interpreted and reinterpreted, and that in the final thesis this process needs to be made explicit.

19/4/11

19 April 2011
15:41

Did my first observation today.

Hard to tell but I think it went ok. I followed the recommendations from Gavin and Jacqui re how to focus what to look at based on the interview data, I have to admit this helped a lot (not typed my field notes yet though so hard to tell)

I was initially worried regarding consent etc, a lot of the people in the MDM were not AHP's and therefore had not been introduced to the research until today.

I got there early and double checked with the sister on duty that it was still ok for me to go in and she said fine, I also touched base with the therapy staff. The physio there was a locum and has only been employed for a few weeks so did not recognise me, thankfully her PTA did, he remembered me from when I did my initial talk with the team and so kind of vouched for me. It was useful to have this link legitimising my presence, although to be honest all the staff involved in the MDM were more than happy with me being there (no one rejected to it anyway!!)

At the start of the MDM I introduced myself and gave a very brief outline of the research and asked if anyone minded if I sat in. I sent round the consent forms but collected them at the end. No one objected and all signed however, in hindsight it would have been more ethical maybe to have collected the forms before the meeting started?

There is also the issue of peer pressure regarding participation which I don't think was an issue in this case but it could have been!

I chose the classic non-participation style of observation, sat in the corner with my clip board and pad. Initially I think participants were conscious of my being there (they kept offering me biscuits) however as the meeting went on I think and felt that this was less of an issue. Note the meeting went on for 2 hours!

Writing field notes was difficult to begin with. I tried to pick out issues that had been previously recognised from the interviews, then I tried to write things down verbatim. After a while though I got into a rhythm, the themes from the interviews did guide me a bit and I did still try and capture quotes, however, I found myself also just going along with it picking up body language, exchanges etc. I also became less conscious of my prompts, and more interested in what the participants were saying. It would be naive to say that the themes from the interviews did not structure the observations, however, I feel that I was able to capture other information.

Time will tell, I need to spend the rest of the afternoon tidying up the field notes so will reserve comments until after that.

18/11/10

18 November 2010
16:05

Interviewed PT ortho 2 today - I wrote my reflective notes straight away after the interview in rough and am now transferring them onto one note - I can really see the benefit of writing these reflective notes now...

Any ways - key issues which I thought important from this interview

Frustration - re planning - this is a personality thing, and the interviewee said so (but off tape!) it is one of those things she just has to deal with

The separation of the self from the professional i.e. the personal and the professional the latter being moulded by the culture in which you work this seemed clear in her descriptions of the difference of the private and public sectors

Risk of litigation is a major driver in the NHS - the top don't want complaints therefore this is a key driver in what you do with the patients and which patients are seen - not a clinical decision but an organisational one

Note she did say deep down she actually enjoyed it here!!!

Section three:

Development of methodology

14 July 2011
09:41

Notes from LeCompte and Schensul (1999)

I was aware that this was going on, it just felt natural, taking a point or issue raised by one interviewee and then confirming it or discussing it with another felt like the right thing to do, I was aware that the direction of my questioning was influenced by previous responses as well as by theory and pre-reading, and my own assumptions. I guess one aspect of the analysis of the cases would be to look for instances of this and say how it shaped the overall construction of the story. An Audit trail of how from the initial interviews the themes have developed, the analysis has unfolded.

"The recursive process of questioning constantly; getting answers; asking more refined questions; getting more complete answers; and looking for instances that clarify, modify, or negate the original formulations permits ethnographers to record their sense of what is happening" p. 11

The process of recursive analysis - begins from the moment you enter the field
In the field analysis has been described by LeCompte and Schensul as having three aspects

Inscription, description and transcription

Inscription - the act of making mental notes, these can be and are jotted down, it is evident in my interviews that I did this (not aware of it at the time) where I am refer to my notes, picking up on what the respondents have said, points to go back to etc
Inscription shapes the focus for observation, although limited in my first two cases, it is there, noting what was said and who said what but also the responses.

It is acknowledged that act of inscription is in part shaped by the initial propositions and past experiences of the researcher (p. 15). I would agree with this however, you can see in my work, that as the processes of analysis begin and develop through out the data collection phases there is a shift in focus to issues raised by the respondents not just by the researcher, this is significant as it indicates and clearly highlights the shift from abstract to ethnographic concerns.

Description, writing things down, this activity follows inscription, field notes etc helps to develop the thick descriptions which are part and parcel of ethnographic work

Transcription:

Verbatim recording, this I have done more formal than description i.e. it is what actually happened (see p. 19)

This next point is key and underlines the need for reflexivity - "it is important to remember that both written and audio- or videotaped transcription always involves conscious or unconscious selection and translation (i.e. the process whereby the research describes in his own words the concepts or ideas based on what the people say). Thus, whatever the informants say and do, items from their speech and behaviour still are selected for recording and then recorded with the researcher's purpose in mind and with their utility in constructing an overall argument for the study - even when the researcher is taking verbatim notes or is using a recording device. The ethnographers observations and subsequent descriptions and transcriptions are filtered through his or her personal, professional, cultural and theoretical lens." p. 31

Note this comes back to Giddens argument about second order categories, the move

Random notes

16 November 2007
15:00

Note a case is not a sampling unit
You sample within a case!!



Unit of analysis = question
How captured = methods
How interpreted = analysis (thematic stop at the point of saturation)
How organised = methodology

← This has a geographical and temporal element i.e. place and time

Note aside from this is the framing of the research question i.e. The propositions and the ontology

Note can not make statistical generalisations from qualitative research but you can make theoretical/analytical generalisations

My propositions frame and provide the theory behind the questions note I am not testing propositions rather I am exploring them

Methodology should link between the method and the aims and back again

Yin, 2003 - case study design

What is key is my unit of analysis
-professional roles and identities
Perception of self in the role- this is key as it links the data collection method with the design i.e. case based to ontology

LINK TO SOCIAL THEORY

03 June 2011
16:15

Functional perspectives are coming from a structural perspective in that they believe that social structures/norms etc will somehow influence a person's actions - I agree with this to a point and this is reflected in the lit review.

"As indicated above the use of such models as a guide to empirical research have been questioned. Of major concern is the fact that both the trait model of occupational classification and the functionalist explanations of the role of professionals within society fail to recognise the temporal and contextual nature of the concepts of professional and profession(s) (Freidson, 1994). Taking this into consideration, the trait model of identifying and classifying professions is reflected somewhat in the propositions shaping the formulation of my research questions. The emotive nature of those characteristics associated with the term profession may contribute to the identity individual professionals have (Herdman, 2001; Hampton and Hampton, 2004) or feel they should have (Carmel, 2005) i.e. their professionalism. However, to solely use such a model as a guide to empirical investigation would be, based on the criticisms levelled at this body of work, inappropriate."

But as indicated in the lit review there has been a shift from structure to individual i.e. from macro to the micro, the concept of professionalism has moved toward the culture of professions which I defined as -

A profession is as indicated a distinct occupational group labelled such via the mechanisms already outlined. A professional is a member of one of those occupations labelled as a profession. Professionalisation focuses on the processes of becoming and maintaining the status of the profession or professional, where as professionalism reflects the behaviours, beliefs, values and practices adopted by a particular profession or professional. This final concept is often regarded as reflecting roles, boundaries and identities. Recently the concept of professionalism has been dissected to reflect the more tacit elements of professional practice. Building on the work of Hoyle (1975), Evans, (2008) has divided professionalism into two overlapping concepts that of professional culture which describes the homogeneity of values, ideologies and behaviours of members of a profession, and professionalism, which is embedded in the individual, Evans describes as the single unit of professionalism?. Although delimited in this way for clarity, I acknowledge that professionalisation and professionalism are interlocking concepts.

The adoption of more constructionist or phenomenological perspectives to the study of professions has allowed researchers to move beyond the macro theories of professions, which Friedson has argued have as their focus occupations and the division of labour, as opposed to professions themselves. The adoption of a broader analysis of professions, which draws on a number of sociological frames of reference not just the division of labour or occupations, has allowed sociologists to develop theories addressing professional practice which take account of the micro, individual elements of professionalism and professional practice.

A focus on individual professionals and their work has prompted Freidson (1994) to suggest that any study of professions should primarily adopt a phenomenological approach. The term profession is a socially constructed concept and is used by a number of different social groups in different contexts and at different times to mean different things. To view the term as being fixed is therefore inappropriate. Taking a more constructionist perspective Friedson views the concept of profession as something which is contextually and temporally bound, in addition to this it is a concept which is continually negotiated. Any empirical enquiry moving beyond this negotiation thus moves beyond the concept of profession to the broader field of occupations.

So ontologically we have a dilemma that of agency vs structure or as indicated in the literature functionalism vs phenomenology

This gap has been bridged by Giddens in his concept of STRUCTURATION structure and action are together

Note a key text is 'The construction of society Giddens, A, 1984, a critique of this is by J Clark, A Giddens 1990

Just for clarification social structure = society = action
Social action = the reverse

Giddens bridged this gap with structuration

Empirically a focus on professionalism (actions, roles beliefs etc - is culture therefore ethnography (why not phenomenology - this is to do with professionalism which I touch upon but it is not the focus...)

The rationale for a case study is that context does influence action (and visa versa see Giddens) and this is reflected in things like communities of practice etc etc etc, so the two can be considered together and we have ontological coherence which then filters down into a methodology - and this is reflected in the theoretical and empirical literature surrounding the sociology of the professions

So why ethnography???

Well what does this mean? The study of cultures and what are cultures is not this interaction?

Yes but this does not directly relate to my propositions nor does it clearly rule out differing methodological stances, the creation of my propositions is supported by the literature as are some aspects of the methods employed, however, the label of ethnography does not sit comfortably on the emerging product..

What of institutional ethnography?

To address my research aims, an exploratory case based, qualitative, methodology is regarded as the most appropriate. It is acknowledged that the fields of sociology and the term qualitative research are extensive. In order to provide a rationale for the proposed methodologies a brief account of the epistemological and ontological frames of reference influencing the development of my research questions are provided. The primary ontological stance taken is that personal and actual are actively constructed through interaction with others and the environment, this being in the form of both dialogue (written and verbal) and action (Baszanger and Dodier, 2004). Interactions occur at multiple levels and within as well as across contexts. Acknowledging this requires me as the researcher to view an individual's experience from both a micro and macro perspective. Adopting a broadly interpretivist perspective, and acknowledging that the research questions arose

Not that I was aware of it at the time but this is structuration and

Appendix C:

Respondent's details

Case study one:

Respondent	Gender	Employment details	Number of years qualified
Band 7 OT	Female	Locum	10
Band 5 OT	Female	Rotational	1.5
Band 8 PT	Female	Non rotational	19
Band 7 PT	Female	Non rotational	26
Band 6 PT	Male	Non rotational	10
Ward Sister	Female	Non rotational	25

Case study two:

Respondent	Gender	Employment details	Number of years qualified
Band 6 OT	Female	Locum	8
Band 5 OT	Female	Rotational	1.5
Band 4 OTA	Female	Non rotational	4
Band 7 PT	Female	Non rotational	15
Band 5 PT	Female	Bank	2
Charge nurse	Male	Non rotational	16

Case study three:

Respondent	Gender	Employment details	Number of years qualified
Locality manager	female	Non rotational	25
Band 7 PT	female	Non rotational	13
Band 5 PT	female	rotational	3
Band 6 OT	female	rotational	5
Community Matron	female	Non rotational	19

Case study four:

Respondent	Gender	Employment details	Number of years qualified
Locality manager	Male	Non rotational	24
Band 7 PT	Male	Non rotational	8
Band 6 OT	Female	rotational	6
Community Matron	Female	Non rotational	20
District nurse	Female	Non rotational	16

Appendix D

Ethics:

Section 1 – Copy of UEL ethical approval

Section 2 – Copy of NHS ethical approval

Section 3 – Copy of acute trust ethical approval

Section 4 – Copy of secondary care trust ethical approval

Section 5 – Participant information letter



Professor Gavin Poynter
SSMACS

ETH/09/59

20 November 2008

Dear Professor Poynter,

Application to the Research Ethics Committee: Allied health professional's roles and boundaries in the "new" NHS (G Copnell)

I advise that the University Research Ethics Committee has now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Debbie Dada
Administrative Officer for Research
d.dada@uel.ac.uk
02082232976

Research Ethics Committee: ETH/09/59/0

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:  Date: 22/11/08

Please Print Name: G Copnell,

Section 2 Copy of NHS ethical approval



National Research Ethics Service

NRES Committee London - Fulham

Charing Cross Hospital
Room 4W/12, 4th Floor
Charing Cross Hospital
Fulham Palace Road
London
W6 8RF
Tel: 020 331 17283

Mr Graham, B Copnell
Senior Lecturer
School of Health and Bioscience
University of East London
Romford Rd
London E15 4LZ

sent 19/5/11

11 May 2011

Dear Mr Copnell

Study title: Allied health professionals' roles and boundaries in the "new" NHS. Aim of the investigation: To provide a detailed, contextually bound account of individual's perceptions of their roles and working practices in the "New" NHS

REC reference: 09/H0712/66

This study was given a favourable ethical opinion by the Committee on 06 October 2009.

It is a condition of approval by the Research Ethics Committee that the Chief Investigator should submit a progress report for the study 12 months after the date on which the favourable opinion was given, and then annually thereafter. To date, the Committee has not yet received the annual progress report for the study, which was due on 05 October 2010. It would be appreciated if you could complete and submit the report by no later than 10 June 2011.

Guidance on progress reports and a copy of the standard NRES progress report form is available from the National Research Ethics Service website.

The NRES website also provides guidance on declaring the end of the study.

09/H0712/66: Please quote this number on all correspondence

Yours sincerely


Michael Mullings
Committee Co-ordinator

E-mail: Michael.mullings@imperial.nhs.uk

Copy to: Mrs Debbie Dada
UEL Graduate School
Docklands Campus
University Way
London E16 2RD

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

Mr Graham B Copnell
Senior Lecturer in Physiotherapy
University of East London
School of Health and Bioscience
University of East London
Romford Road
Stratford
E15 4LZ

17 March, 2010.

Research & Development Office,
c/o Academic Centre,
NEWHAM GENERAL HOSPITAL
Glen Road, Plaistow,
E13 8SL.

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Dr Shanti Vijayaraghavan, Director of Research &
Development (R&D)
Ms Neeta Patel, R&D Manager
Ms Doreen Ampomah - Asiedu, R&D Co-ordinator

Dear Graham,

Re: Allied Health Professionals' Roles and Boundaries in the "new" NHS.

Thank you for providing us with information concerning the above study. This letter is to confirm that the Trust has approved the study and, is providing indemnity to cover the involvement of Newham University Hospital NHS Trust staff and any staff with an honorary contract at Newham University Hospital NHS Trust for purposes of the study. The approval is provided on the understanding that the University of East London has agreed to be the official SPONSOR for the study and has ensured adequate indemnity and monitoring arrangements. In addition, as the Chief Investigator, you must ensure adherence to the ethically approved study protocol and responsibilities outlined in the 'Research Governance Framework for Health and Social Care', 2nd Edition, DH April 2005.
http://www.dh.gov.uk/en/Researchanddevelopment/A-Z/Researchgovernance/DH_4002112

Please inform us if your project is amended and you need to re-submit it to the Ethics Committee **and when the project terminates**. This is necessary to ensure that your approval/indemnity is valid and also helps the office to maintain up to date records. Should any untoward events or incidents occur, then it is essential that you immediately contact the Trust Risk Management Team (020 7363 8507 / 8417) and the R & D Office at Newham. We would also ask that you keep us informed of any publications or final reports that are produced as a result of the research.

Please do not hesitate to contact either Neeta Patel (R&D Manager) on 020 7363 8923 or myself on 020 7363 8001 if you have any further questions.

With best wishes for the study,


Dr Shanti Vijayaraghavan,
Director of R&D

cc Ms Deidre Barr, Deputy Chief Operating Officer, NUHT; Joanne Morris, R&D Lead, NUHT.

Section 4 Copy of secondary care trust ethical approval

FINAL R&D APPROVAL

15th February 2012

Mr Graham Barrie Copnell
Senior Lecturer in Physiotherapy
University of East London
School of Health and Bioscience
Romford Road
Stratford
E15 4LZ

Joint Research and Development Office
Queen Mary Innovation Centre
5 Walden Street
Whitechapel
London
E1 2EF

Tel: 0207 882 7250
Fax: 0207 882 7276

Dear Mr Copnell

Protocol: Allied health professionals' roles and boundaries in the "new" NHS. Aim of the investigation: To provide a detailed, contextually bound account of individual's perceptions of their roles and working practices in the "New" NHS
ReDA Ref: AD1201/3
REC Ref: 09/H0712/66

I am pleased to inform you that the Joint R&D Office for Barts and The London NHS Trust and Queen Mary, University of London, has approved the above referenced study and in so doing has ensured that there is appropriate indemnity cover against any negligence that may occur during the course of your project, on behalf of East London Foundation Trust. Approved study documents are as follows:

Type	Version	Date
REC Approval		06 October 2009
REC Application	2.0	16 July 2009
Protocol	2	02 January 2010
Participant Information Sheet: Team leader letter	1	02 July 2009
Participant Information Sheet: Study information for participants	2	29 September 2009
Participant Information Sheet: Information for service user	2	29 September 2009
Participant Consent Form: Participant interview consent form	1	02 July 2009
Participant Consent Form: Participant observation consent form	1	02 July 2009
Participant Consent Form: Patient/client observation consent form	1	29 September 2009
Participant Consent Form: Patient consent for observations post hoc	1	29 September 2009
Interview schedule/topic guide	1	02 July 2009
Lay summary	1	02 July 2009
Letter from sponsor: University of East London		13 March 2009
Evidence of insurance / indemnity: Zurich Municipal		08 July 2011
Funding letter		30 March 2009

Please note that all research within the NHS is subject to the Research Governance Framework for Health and Social Care, 2005. If you are unfamiliar with the standards contained in this document, or the BLT and QMUL policies that reinforce them, you can obtain details from the Joint R&D Office or go to:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962

You must stay in touch with the Joint R&D Office during the course of the research project, in particular:

- If there is a change of Principal Investigator
- When the project finishes
- If amendments are made, whether substantial or non-substantial

This is necessary to ensure that your R&D Approval and indemnity cover remain valid. Should any Serious Adverse Events (SAEs) or untoward events occur it is **essential** that you inform the Sponsor within 24 hours. If patients or staff are involved in an incident, you should also follow the Trust Adverse Incident reporting procedure or contact the Assurance department via Incident.Reporting@eastlondon.nhs.uk.

Head of Research Resources: Gerry Leonard

Barts and The London 
NHS Trust

We wish you all the best with your research, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Yours sincerely



Gerry Leonard, Head of Research Resources

Copy to:

Dr Kate Corlett (Local Collaborator at East London NHS Foundation Trust),
Associate Medical Director Primary Care, Community Health Newham, East London
NHS Foundation Trust, Warehouse K, 2 Western Gateway, London, E16 1DR.

Karin Albani, Research Manager, East London NHS Foundation Trust.

Mrs Jacqueline Potter, University of East London, School of Health and Bioscience,
Professional Health Sciences, Romford Road, Stratford, London, E15 4LZ.

Mrs Debbie Dada, Administrative Officer for Research, UEL Graduate School,
Docklands Campus, University Way, London, E16 2RD.



University of East London
School of Health and Bioscience
Professional Health Sciences
Stratford Campus
Romford Road
Stratford
London E15 4LZ

INFORMATION SHEET FOR PARTICIPANTS

If you have any queries regarding the conduct of the programme in which you are being asked to participate please contact the Secretary of the University Research Ethics Committee: Ms D Dada, Administration Officer for research, Graduate School, University of east London, Docklands Campus, London, E16 2RD (telephone 0208 223 2976 e-mail d.dada@uel.ac.uk)

Programme of Study:

Doctor of Philosophy (PhD)

Title of Project:

Allied health professional's roles and boundaries in the "new" NHS.

Dear Participant,

You are being invited to take part in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Background:

The structure and organisation of public sector professionals' activities have been questioned; this is most evident with regards to health service professionals. Rationales for changes in how professionals work have been presented as financial or ideological, and the research into the impact of such changes has focused on these aspects. To date little research has addressed the impact of these changes from a professional's perspective, in particular on a professional's identity or their working practices.

What is the purpose of the study?

The principal aim of this project is to investigate the working practices and professional identities of public sector health care professionals, focusing specifically on the therapy professions.

The project aims to provide insights to the following questions:

What issues do allied health professionals feel are important with regards to professional identity and occupational boundaries?

How do different professionals negotiate and articulate their roles and identities in their working practices?

The following propositions frame the research questions:

Occupational boundaries and identity are fluid and negotiated

Role negotiation and professional activities will vary depending on the context of care

Developments in the NHS are leading to the development of a new kind of health professional

Proposed is a case based ethnographic study incorporating in-depth interviews, field observations and document analysis. Each case will consist of a team of health care professionals working with clients with long term conditions.

The project will involve health care professionals working in both community and secondary care settings with clients who have long term conditions. Two cases will be chosen from the community setting and two from secondary care.

What will I have to do if I take part?

A case study will last up to 5 months in total. A series of interviews and observations will serve as the primary data collection methods. Service policies will also be analysed. You may be involved in both interviews and observations the details of which are outlined below.

Interviews:

All interviews will be individual. Each interview will last approximately one hour. I would like to interview you twice. Interviews will be digitally recorded and transcribed. Each transcript will be coded and any material leading to your identification will be removed. All recordings and transcripts will be kept at the University of East London on a password protected drive in a password protected file. Copies of transcripts will be sent to you for checking at which point you may wish to change or add to the answers given. The data generated from interviews will be analysed thematically, the results of which will be sent to you for checking. All interviews will occur at your place of work or on University premises unless otherwise stated by you. Regardless of location all interviews will occur in private.

You will be asked to provide both written and verbal consent before and during any interview is undertaken.

Observations:

It is anticipated that observations will be of staff meetings and joint treatments sessions. The maximum number of observations per case is estimate to be ten. The foci of the observations will be on capturing the dynamics of role negotiation and identity formation. Where possible both written and verbal consent will be gained before the observations. Although consent can not always be sought from individuals prior to data generation in observational studies all steps will be taken to gain consent post hoc (SRA 2003). It is acknowledged that due to the nature of the field work the researcher may come into contact with patients, service users or members of the public. The focus of observations will be on the work of the professionals, with this in mind it is important to state that no patient or service user data potentially compromising confidentiality will be collected during any stage of the study. An information letter for patients describing the

research and the observations will be provided. It is anticipated that observations will occur within your place of work. The data generated from observations will be analysed thematically and inform both subsequent interviews and observations.

Analysis of Policies:

Documentation analysis allows the researcher to contextualise each case at both a local and national level. A focus on documentation allows for analysis of how practice is being formalised and communicated in a formal way. Documentation outlining working practices for example assessment forms or treatment protocols will be examined. Again thematic analysis will be employed. All data leading to the identification of individuals, services or organisations will be removed in the final write up of each case and the study over all.

What are the possible advantages of taking part?

It is hoped that by taking part in this study you will be able to reflect on your current working practices and role and how these relate to other members of your team.

In general it is hoped this research will illuminate the types of issues AHPs face regarding their roles and professional boundaries, and how these are manifested and shaped by the work place. It is anticipated that this information will be of interest to AHPs, managers, professional bodies and educators

What are the possible disadvantages or risks of taking part?

There are no anticipated risks to you by being involved in this study.

Do I have to take part?

You are under no obligation to participate in this study. If you do decide to take part, you are free to withdraw at any time without giving a reason. If you do not take part or withdraw from the study at a later date, it will not disadvantage you.

What will happen to the information?

Your participation in this study and all information collected will be kept strictly confidential. Where necessary, information collected will be coded so that you cannot be recognised from it. The results of this study will be reported as part of my degree programme and may be further disseminated for scientific benefit. The results will be available to you on request.

Who should I contact for further information or if I have any problems/concerns?

If you have any concerns or would like further information please contact either the primary research or the project supervisor.

Primary researcher:

Graham Copnell

University of East London

School of Health and Bioscience

Professional Health Sciences

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Project supervisor:
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