The
University
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Teamwork and interprofessional networks in stroke care:

towards an understanding of joint working practice.

Volume 2

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5. DISCUSSION

The previous findings section presented data describing a number of elements of joint working practice within six domains of the organisation, team process, the individual, communication, professionalism, and the service user. In this discussion section the data will be further considered in relation to the research questions, which prompted this investigation, to move the study from purely description to interpretation. Each research question will be considered in turn, using the study findings to discuss how they may contribute to a better understanding of joint working practice in stroke care.

5.1 WHAT ARE THE SIGNIFICANT ELEMENTS OF JOINT WORKING PRACTICE WITH STROKE PATIENTS?

The study can begin to answer this question, by exploration of its findings regarding domains and elements of joint working practice uncovered during the three investigations of sites providing care to stroke patients. Figure 5 presents the elements that were described in the previous section; in the form of a framework that this study proposes illustrates the significant aspects of current joint working practice with stroke patients. The impact of each of these elements on the reality of joint practice will now be discussed, and the findings from this study will be considered in relation to work by other authors.

Figure 5. Elements of joint working practice

1. The organisation	2. Team process	3. The individual	4. Communication	5. Professionalism	6. The service user
Management structure	Training	Personality	Formal communication	Status/power	Care group
Organisational conditions	Goal/ purpose	Trust/ respect	Informal communication	Role and identity	Role of user
Location of staff	Group norms	Previous experience	Written communication	Length of experience	
Time	Contact frequency		Confidence	Knowledge and skills	
Context	Leadership				
	Team size				
	Decision-making				
	Group Support				

1. The organisation

The literature review highlighted the importance of the organisational context in effective joint working, and the influence of external factors, over which the staff may have little or no control. Bateman et al. (2003) argued that joint working needs organisational support in order to function successfully and this study supports the need for the organisational context surrounding joint working with stroke patients to be fully considered. The findings of this study highlight the impact of the location of staff, management structures, organisational conditions, time, and context on staff joint working practice.

- **Location of staff**

The formation and functioning of joint working in the three cases studied was adversely affected by work environments, which divided staff into different offices or parts of a building or even different buildings. The data emphasises the

significance of factors such as shared offices in joint working, with a tendency for "teams within a team" to form where employment conditions, and working environments are not shared. This finding that the location of staff impacted on joint working in the sites studied echoes work by Suter et al. (2006) in Canada, who identified the need to create joint space as a key strategy to promote joint working practice in healthcare.

- **Management structure**

Joint working in the sites studied here was also adversely affected by complex management structures. Salas et al. (2005) consider one of the key aspects ensuring successful team functioning across all organisations including healthcare is "mutual performance monitoring". However, a significant feature of the cases studied was the complex managerial structure, with performance appraisal either within the individual professions at the site, or via same-profession staff outside of the site, with little shared accountability for performance.

- **Time**

A key concern of staff regarding joint working was in regard to the additional time that working in this way required. It is possible that this perception of increased time required could link to the changing staff membership impacting on task efficiency, which will be outlined further in regard to team process. Time concerns were frequently mentioned in regard to the formalised contacts at staff meetings at two of the study sites, with staff expressing concern at the time taken up by attending meetings on their patient contact time. As much of the decision-

making and communication appeared to be outside of these "formal" meetings their concerns seemed justified. However, staff meetings served a function of "rubber stamping" decisions, in particular decisions regarding discharge. Also, meetings are one of the main measures that is used in the UK as a performance indicator of joint working in stroke services (see DOH, 2001, Royal College of Physicians, 2004a), thus are seen as a requirement for services. This study suggests however, that the time that these meetings require needs to be fully explored and justified.

- **Organisational conditions**

The finding that the organisation has major significance for joint working practice is supported by the work of Anderson et al. (2005). They argued that there is a tendency for "the physician" to be considered the most important point for change, whereas in reality "it is within the context of the organisation itself that many of the answers lie for understanding and improving healthcare delivery". The work of Van Raak et al. (2005) similarly emphasises the need for greater understanding of the impact of the organisational dimension on joint working and highlights the need for an examination of organisational motivators. This study was conducted at a time of considerable organisational change, and staff highlighted the impact of factors outside their control on their practice, in particular in regard to length of stay policies, changes in staffing, and patient types admitted to the care of the site.

The literature review considered the application of Systems Theory and Complexity Theory to examination of the organisational dimension and the data

supports the need to consider joint working as part of a larger, complex structure, with Systems Theory providing a helpful theoretical underpinning for this.

This finding is supported by Kennedy (2006) who describes current changes to working practice in UK healthcare as being part of a "systems reform", with a need to link together strands of healthcare policy into a coherent whole. The work of Elias (1978) was also highlighted in the review, and emphasises the need to consider organisations as dynamic and interdependent, with the complexity of social processes "limiting the ability of even the best managers to control such processes" (Dopson, 2005). Elias' work was particularly related to managing innovation and processes of change, and is thus of particular relevance to the NHS, where, as the data highlighted, joint working practice is taking place in the context of frequent organisational change. The interrelationship of elements, in particular the influence of elements of organisation impacting on other elements, is a significant feature throughout the following sections.

Findings from this study thus highlight that organisational factors are a key element of current joint working practice for stroke patients. It identifies that within this element of practice, management structures, organisational conditions, time, and the location of staff can have an impact on functioning, and need to be fully considered when describing, evaluating and comparing working practice. The impact of organisational conditions will be returned to throughout this discussion section.

- **Context**

The impact of the context on current joint working practice was highlighted in terms of the need for different working practices between community care and hospital care, with the two contexts presenting different challenges, and also with a key aspect of team process, that of goal planning differing between hospital and community services. The role of the context in determining working practice was also considered in regard to the differing role and status of the medical profession compared to other staff, and also the difference between medical and rehabilitative models of care. The impact that this finding regarding the significance of context has on descriptions of different types of current working practice will be further considered later in this discussion section.

2. Team process

- **Team size**

An element of joint working practice linked to organisational factors is the composition of the number of staff who are considered to be "the team". The study findings suggest that the number of individuals on a site seemed to impact on whether the site as a whole functioned as "a team", or whether there were a number of teams formed. The sites examined contained up to fifty individuals who were considered to be "the team". This is a number that (as outlined in the review of the literature) the teamworking literature, particularly from other disciplines outside healthcare would consider too large for the necessary team process functions to operate. In the cases studied here, it is possible that the number of individuals at the two largest sites contributed to the formation of sub-teams that the data describes as "teams within a team". In the data, there were

sub-teams formed at two of the three sites, which had larger numbers of staff, with the other, smaller site seeming to function as a single team.

The number of staff is not the only factor in determining functioning as this interpretation will outline further later, but may be significant in the formation of sub-groups. This study therefore emphasises the need to consider the size of staffing groups more fully in planning joint working, if team functioning is to be achieved, thus echoing the call for more research to determine optimum team size in stroke care (Royal College of Physicians, 2006).

As mentioned above, team size, was a core element impacting on working practice, with changing group membership as a result of different employment conditions, and profession-specific factors such as staff rotation, outside the team's control. This interpretation of changing membership impacting on functioning is supported by Prichard et al. (2006) who concluded that the consistency of team membership was a significant factor in the efficiency of joint working, with teams who had disrupted or changed membership losing shared understanding of tasks and of each other. Prichard et al. describe changing team membership as hindering the distribution of workload and lengthening the time taken by individuals to perform tasks. In the joint working described in this study, changing staffing was a key feature, which may have significantly impacted on team process.

- **Contact frequency**

The ability to work together was affected by contact frequency, which was influenced by the working patterns and location of staff determined largely by organisation factors. The literature review considered the application of Co-operation Theory to joint working with Loxley (1997) highlighting frequency of contact to be the most significant factor determining levels of co-operation between healthcare staff. Contact amongst the staff in this study was affected by organisation factors of: different working hours amongst staff; lack of consistency of team membership caused by re-deployment of staff; and organisational change; factors, which it is argued, adversely impacted on team process. This study thus highlights the need for attention to be paid to elements of team process such as contact frequency, in the establishment and evaluation of joint working practice in stroke care.

- **Decision-making**

The formal mechanism of decision-making was perceived by staff to be the multi-disciplinary team meeting, with the need for these meetings required as a main measurement of joint working in current audit. Whilst staff perceived that the meeting was the central focus point for discussion and decision-making, this did not seem to always be the reality of joint working. At two of the sites the meetings were used exclusively to discuss patients. At another of the sites, the meeting served the purpose of predominantly a general information-exchange and training function. Thus, although all three sites were achieving the requirement for a weekly meeting, and therefore achieving this measure of

successful functioning in stroke care (Royal College of Physicians, 2006) the content and purpose of these meetings differed considerably.

These different functions of the meeting may be another factor perpetuating the formation of sub-groups at two of the sites, with the third avoiding sub-groups developing by paying more attention to team process at the weekly meeting. This study therefore suggests that the content of meetings needs to be considered fully, and their purpose made clear, as merely identifying that a meeting occurs, as in current measures, does not describe the reality of joint working or enable comparisons between types of joint working to be made.

This perception by staff that the multidisciplinary staff meeting was the main forum for decision-making is worthy of further examination. Wittenberg-Lyles (2005) described dissonance between the perception of, and the reality of meetings, and this is echoed by the data here. The work of Fleissig et al. (2006) also supports a conclusion that meetings were not the primary means of deciding care. They highlighted that decisions made at staff meetings were not always implemented, and that joint discussion did not necessarily improve the quality of decision-making. A similar point is made by Verhoef et al. (2006) in their analysis of team conferences in rheumatoid arthritis. They noted that the meetings were principally a means for information exchange, much of it discipline-specific.

At two of the sites studied here, even though the meeting was exclusively to discuss patients, and there was information exchange, rather than the meeting

being the decision-making forum, the informal systems seemed to be the more powerful for making decisions amongst staff regarding ongoing care and co-ordination of care. At these sites the meeting seemed to serve the function of discharge ratification requiring the authorisation of medical staff, with decisions already having been made amongst staff sub-groups, and organisational conditions driving the need for decisions to be made. Thus, it is argued that having a weekly staff meeting, as one of the current main measures of joint working in stroke care, does not fully capture the reality of functioning.

Joint decision-making may not have primarily occurred at the multi-disciplinary meeting, but in the data there is much evidence of discussion regarding decisions amongst staff, and joint decision-making was highlighted by staff as being one of the key advantages of working together. Decisions regarding care of patients operated at the uni-professional and sub-group teams level, and staff reported that discussion with colleagues aided problem-solving and clinical decision-making. This ability to discuss cases was frequently linked in the data to frequency of contact, and close location, with these organisational factors again impacting on team process.

- **Training**

There was little evidence in the data that joint working had been fostered by staff receiving training in how to work together. Some staff recollected receiving training during their initial qualifying course, but there were no reported examples of training that staff considered beneficial to their joint working practice. Authors, such as Prichard et al. (2006) and Sparrow and Heel (2006)

emphasise the importance of team skills training and team learning in successful functioning. Prichard et al. argue (2006) that there is little evidence to support the assumption that individuals "either already possess the necessary skills to work effectively together, or that these skills are developed by the simple imperative to work together". This assumption however seemed to exist within the organisations studied.

- **Group support**

Although staff reported feeling supported by working with other professionals, there seemed to be only informal or implicit mechanisms of support operating, and similarly implicit norms or expectations of group member behaviour, resulting in seemingly little attention being paid to the development of team process factors to enable or extend teamworking. This was a particular feature at two of the three study sites, where team support operated amongst sub-groups rather than the site as a whole. At the third site there were support mechanisms operating linked to staff being in a single location with frequent informal contacts such as over lunch, suggesting that closeness of working location may again be of significance in determining type and level of joint working practice.

- **Goal/purpose**

The identification of goals seemed a challenging area for staff at the sites, with different perceptions of goals amongst individual staff. As a key indicator of successful joint working identified in the literature review it is suggested that the lack of a clear goal/purpose may have been another contributing factor in sub groups becoming established, with profession-specific, or allied health groups

working towards the same goal, but differing goals across whole sites. This work suggests that the reality of practice is that the identification of shared goals remains a key challenge in healthcare joint working. This identification of a lack of joint goal setting echoes work by other authors. Atwal and Caldwell (2006) for example reported in their study of acute care at three sites that "there was no evidence of multidisciplinary team goal setting". The findings from the work reported here suggests a slightly more positive outlook than this complete lack of shared goals, with the beginnings of joint goal setting amongst allied health professionals but a considerable lack of shared purpose across sites. This could link with the section above describing the lack of evidence of training staff in joint working at the sites studied. In the UK the Connect charity has been offering a training programme (The Good Goal Setting Guide) for some years, offering whole team training in joint goal setting. The Connect philosophy emphasises that "goal setting is a critical part of a person's journey through therapy and support services" (Connect, 2007), with "good goal setting underpinning both a fulfilling life after stroke and best use of therapy and community resources". The training seeks to provide staff with skills in setting person centred and accessible goals, and training such as this seems to continue to be a priority if team goal setting is to become a reality.

This lack of whole site goals is perhaps not surprising, as the literature review highlighted the complexity of goal planning in healthcare and the changing role of the patient (to be discussed in regard to the fourth research question), which adds to shared goal planning challenges. The literature (for example Poulton and West, 1997, Hall, 2005) however emphasises however that clarity of objectives is

a predictor of effectiveness, and is thus an important area to be addressed in facilitating joint working. Recent studies (Levack et al. 2006, Hurn et al. 2006) that carried out systematic reviews of literature relating to the effectiveness of goal planning in healthcare however, present a less clear picture regarding links between goal planning and healthcare outcomes. These studies report the wide use of goal planning in rehabilitation settings but found mixed evidence that it contributed to improved patient outcomes. Both studies highlight that the reviews were limited by the number of different purposes or functions that were attributed to goal planning. This echoes the findings from this study that there are currently different perceptions of goals amongst staff, which may contribute to different types of joint working in different locations.

- **Leadership**

Another element of functioning highlighted as important in the literature review is the element of leadership. There was variation in the sites studied in terms of leadership structure with a strong tendency for leadership functions to be fulfilled via senior members of each profession, rather than an overall site leader. Here again the influence of organisational conditions is strong, as the organisation dictated employment and managerial systems, with responsibility for individual staff often outside of the location creating a problematic leadership role. The power and status issues (to be discussed later) also impacted on leadership within two of the sites, where medicine was viewed as the profession with power and status, but not officially occupying the "leadership" role. The literature review highlighted the changing views of leadership (see for example Ensley et al. 2006, Day et al. 2006), with growing tendencies towards shared rather than vertical

leadership mechanisms. The findings from this study suggest that the different forms of leadership operating within sites need to be clarified in descriptions of joint working practice, as different leadership models may be associated with different types of joint working.

In the a priori framework (that was developed from the pilot study, and from reading of the literature) an additional element of team process had been proposed relating to conflict within the team and conflict resolution. Within the data there was no evidence of conflict featuring as an element of practice, which is perhaps surprising. The relationships amongst staff certainly appeared to be harmonious, with no reported or observed conflict occurring during the data collection episodes, and thus conflict was not identified as an element within the framework proposed.

Conflict however is believed to be an important mechanism for change (see for example Davison, 2004, Erdem, 2003). The literature warns of the dangers of "group think", where services become overly cohesive and resistant to change (West, 1994, Reeves, 2006). The existence of a number of teams within the staff groups at each site may be a driver to avoid a group think mentality occurring, and could be seen in this aspect to be an advantage for a service, rather than a single team providing care. The sites gave no indication of being unresponsive to change, and indeed were operating in a system of frequent organisational change. It is possible that conflict was perhaps targeted towards external influences surrounding the sites in relation to organisational conditions and management, rather than being targeted within the site. It is also suggested that

perhaps conflict was avoided due to power and status issues which will be considered in relation to professionalism, or alternatively that the positive individual elements (to be discussed later) led to avoidance of conflict.

3. The individual

The impact of individual staff's perceptions and previous experiences of joint working was highlighted as significant in the literature review. The importance of the individual is highlighted in work by Elias (1978), which has already been referred to in relation to organisational conditions. Elias argued that individuals should be viewed as being in a dynamic relationship with other people and with the context, with their values and interests intertwining in their actions. His "game models" describe the complexity of interactions between individuals, and how as numbers of individuals in "a game" increase, that individual control and intended outcomes can become less planned or anticipated. This description of increasing complexity as the number of individual "players" increases links in with the first of the team process elements to be described, the element of team size. In this Elisian view, it would be anticipated that the relationships between the large numbers of individuals who where working at each study site would be highly complex, with the potential for the situation to be unpredictable, with increasing difficulty for individuals to put together an accurate mental picture of the situation as a whole (Dopson, 2005).

It is important to note in the data that there was perceived to be a significant relationship between individuals and organisational conditions in which they operated, such as individual profession staff rotation systems, and employment of

individual professionals, rather than employment to the working context, leading to the composition of the staff group being largely outside of the service's control. There was some evidence of joint interviewing by staff members together with representation from specific professions when appointing team members at two of the sites, but rotation of staff meant that especially in nursing, medicine, and physiotherapy, individuals were entering and leaving the site on a regular basis. These factors added to the complexity of establishing individual relationships at the sites, and may contribute to an unpredictable system and outcomes.

The data describes one of the perceived benefits of joint working for staff, to be a supportive environment. For this benefit to be achieved, the organisational conditions are once more significant in providing conditions that enable functioning to be supported, such as close location, and frequent contact between individuals. Some staff reported that their previous experiences of joint working had often been unsatisfactory, and there was a perception that joint working in stroke care was "ahead" of working practice in other areas.

The data contains mention of individual qualities of trust and respect and also individual qualities of motivation, and flexibility. This supports work outlined in the literature review, which emphasises the need for an individual to fit within a service - the "person organisation fit" (Burch and Anderson, 2004), also Lawson's (2004) description of "social trust" that is required in joint working. Loxley's (1997 p.40) discussion of Co-operation Theory in relation to joint

working similarly highlights the need for parties to bring "the willingness to trust the other" to collaboration if there is to be mutual benefit.

The literature would thus support the importance of individual factors and relationships identified by the studies. It is suggested that the formation of trust amongst staff, perceptions of the need for mutual respect, and the importance of organisational systems as impacting on effective joint working are of significance.

4. Communication

Good communication was perceived by staff to be one of the most significant aspects of joint working. The distinction between formal mechanisms and informal mechanisms was described earlier in relation to decision-making processes. The significance of informal channels of communication is a key factor in describing the reality of working practice at the locations studied. The importance of communication in functioning supports the need for staff training in communicating with other professional groups, echoing the work for example of Boaden and Leviss (2000) and Rider and Brashers (2006).

Formal communication channels such as multidisciplinary meetings are one of the main measures of functioning, employed in for example the Stroke Care Audit (Royal College of Physicians, 2004). This study suggests that measuring these formal communications does not accurately reflect joint working. Written communication, such as multidisciplinary record keeping, similarly seems an attractive way of measuring joint working. At the sites studied however, there

seemed to be a preponderance of written information, but staff expressed the limitations of written systems, seeming to prefer an informal transfer of information either to supplement, or instead of, the written information.

This finding is supported by the work of Chua and Ngee (2001) who highlighted that the type of knowledge or information to be shared should dictate the type of communication system to be used. They found that where more tacit or complex knowledge needs to be transferred it should be communicated via a "media rich" or highly interactive channel such as face-to-face conversation, suggesting that transferring complex information regarding patient care via "low media rich channels" (Chua and Ngee, 2001) such as written memos or case notes may not be preferable to social interaction amongst staff. This may explain the use of informal communication systems identified in this study. The influence of organisational conditions is once more indicated within this element, as the location of staff and frequency of contact will determine whether informal communication exchanges are able to happen.

5. Professionalism

The literature review discussed the importance of notions of professionalism in healthcare, and this aspect as marking healthcare apart from joint working in other fields such as business and management. The data relating to professionalism will be discussed in relation to the areas of knowledge and skills, role and identity, and power and status.

- **Knowledge and skills**

The previous section presented data illustrating the importance of exchange of knowledge and skills in joint working, which seems to be at variance with traditional notions of professionalism where individual professions have discrete areas of knowledge and skills. Loxley (1997) would argue that the study was describing processes explained by Social Exchange Theory, whereby the exchange of knowledge and skills (which she terms reciprocity) is based on calculation of return or perceived benefit, and certainly the staff members identified the benefits of sharing knowledge to them. The organisational conditions also had a role in creating a need for knowledge and skills transfer, as working hours created a single profession (nursing) that provided twenty-four hour care at two of the three sites, resulting in the nurses taking on many elements of care that formed part of other profession's roles. This finding echoes a recent study by Apker et al. (2006) who similarly emphasised the co-ordinating role played by nurses.

- **Role and identity**

The literature review discussed the relationship between knowledge, and role and identity, and the importance of role clarity for joint working. Authors such as D'Amour and Oandson (2005) propose that knowledge exchange would result in reforming of professional boundaries. The data suggests that there was considerable evidence of knowledge transfer between professionals, and that the study participants believed there to be some blurring of boundaries. However, it is argued that there was in fact little evidence of role blurring, with the data identifying clear areas of role clarity and primacy for each professional group

(see Table 7) with role clarity being apparent in observed and reported practice at the sites, and with role distinctions being linked to depth of knowledge.

The literature on professional knowledge would suggest that the preservation of professional boundaries linked to depth of knowledge is explained by the complex nature of professional practice as being more than a collection of knowledge and skills (or competencies). Fish and Coles (2000) describe the "professional artistry", Schön (1983) the "grey areas of practice", and Hall (2005) the "cognitive map" unique to each professional achieved by practitioners as they gain experience and become "expert" (Dreyfus and Dreyfus, 1986).

In the data, the linking of professional role with having depth or "expert" knowledge suggests that surface level knowledge may be transferred between different professions resulting in some exchange of knowledge and skills, but for blurring of boundaries to take place there needs to be a deeper understanding of the tacit knowledge (Rogers, 2004), complex clinical reasoning (Boshuizen and Schmidt, 2000, Higgs and Jones, 2000), and enculturation (Bromme & Tillema, 1995) achieved by expert (experienced) practitioners in a team to create shared team knowledge (described as shared mental modelling by Jeffery et al. 2005) and blurring of boundaries.

The data supports this conception of knowledge exchange being linked with preserved role boundaries, and knowledge sharing being linked with role blurring in three ways. Firstly, in the description of role boundaries being associated with depth of knowledge rather than discrete areas of knowledge, secondly, by the

data describing the use of senior colleagues by junior staff, and thirdly, the data describing change in joint working practice associated with experience. The data also describes that the situation in which some role blurring was reported as taking place was between senior members of the allied health professions, who it could be argued as expert practitioners were able to achieve shared similar "cognitive maps", and, as allied health practitioners may have similar "enculturation". This perhaps indicates that the three elements of: tacit professional knowledge; complex clinical reasoning; and similar professional culture, are the necessary prerequisites for role boundaries to be reduced, rather than the simple transfer of knowledge and skills that advocates of competency-based views of practice would associate with role blurring.

This argument would suggest that knowledge and skills exchange is possible at a "basic" level, where there is surface rather than deep knowledge. This was indeed the case at the sites, as all had developed a generic assistant staff group who had a role that crossed the professions, a role that required the transfer of knowledge and skills from all the professions. Shield et al. (2006) supports this development of individuals with a more generic knowledge base. They propose the development of an "interprofessional practitioner" role for older people, which would take on knowledge and skills across health and social care.

The background to the study section described the government-led policy drivers for changes to the workforce and the need for role blurring. The assistant role in the sites studied appeared to be fulfilling this need for role blurring, but assistants and qualified staff were at pains to point out that this did not erode the need for

professionally qualified staff. The data from this study suggests that, if discrete role is linked to depth of knowledge and skills, rather than specific knowledge (or discipline) area, then generic roles at an assistant level would follow. However, role blurring at an expert practitioner level requires depth of knowledge, and well-developed joint working skills, with the individual and team process elements of joint working that this study has identified being in place. Only then is it possible to achieve the shared cognitive maps and knowledge sharing (rather than knowledge transfer) that is required for role blurring.

It is also important to recognise that in a systems perspective of practice, which this study supports, any one element is interlinked with others, and the influence of the organisation has already been highlighted in the previous sections as impacting on the other elements. For knowledge and skills sharing and blurring of boundaries to be achieved, along with individuals creating a "shared" or "team knowledge", supportive organisational conditions, individual trust, support, and informal communication systems need to be in place.

- **Power and status**

Another aspect of professionalism that the literature review highlighted is the element of professional power and status. In the data, power and status was associated with decision-making and the medical role. The dominance of medicine in terms of power and status confirms work outlined in the literature review, indicating that changed healthcare practice to date has had little impact on changing power and status assumptions. Colyer (2004) argued that "the

leadership presently vested in medical practitioners must change" if healthcare staff are to function optimally. Kennedy (2006) similarly argues that professionals must be encouraged to redefine their professionalism in order to change power differentials. Loxley's (1997 p.39) discussion of Co-operation Theory emphasises the need for parties to have equal powers if joint working is "not to degenerate into coercion", and discussion of Social Exchange Theory requires recognition of perceived benefit to all participants through joint working.

The data describes the perception amongst participants that the sites were operating in a mostly non-hierarchical system, however the medical profession dominated interactions during staff meetings at two of the sites. These meetings were the decision ratification forum, and medicine had the role of decision-maker in terms of the process of patient care (i.e. referrals on to other agencies, further testing, discharge) and medication. At the hospital-based sites patients were admitted "under the care of the consultant", thus preserving this ultimate decision-making role.

Although the data describes the power of the medical staff, it seemed that this was a perception that was perpetuated by all, but which was not always the reality with non-medical staff formed into profession-specific groups, and sometimes different groupings combining and able to influence decision-making by this association. On these occasions it seemed that the status of medicine was preserved but not necessarily the decision-making power. This echoes Payne (2000 p.142) who reported that "power is a matter of perception not actuality".

However, applying a Social Exchange Theory view or a Co-operation Theory view of joint working (see Loxley, 1997), even where there may be some sharing of the power of decision-making via joint working it is hard to identify a circumstance where medicine could be seen to benefit from erosion of its' status.

The client care pathway of patients who have had strokes is that of decreasing involvement of medicine as care moves from acute to rehabilitation. The data highlights this reducing involvement of medicine, and the change in model of care. The data highlights that the community site was the context where there was whole team functioning, rather than "teams within a team", which may link to the number of staff members, but may be linked with a "status equal" position where there was no medical involvement. Colyer (2004) supports this finding of more teamwork in the community context associated with a status equal position. Hugman (2003) similarly found that community-based services had less hierarchy, which he associated with no presence of the medical profession.

The final element of professionalism that this framework proposes, namely, length of experience will be discussed in relation to the second research question.

As with all the other elements of joint working practice, which this study proposes, it is important to recognise the interrelationship between the elements in describing the reality of current practice. The data from this study has suggested in response to the first research question, that the reality of joint working is a complex combination of twenty-six elements of practice within six key domains. The study has highlighted the ways that these elements can impact

on joint working practice and suggests that if the reality of practice is to change, then these elements need to be addressed.

This discussion will now move on to consider the second research question. It will consider how these elements of practice that have been outlined might be used to describe and differentiate between different forms of working practice in order to clarify the use of current terminology, and begin to explore whether different types of practice may be linked to different impacts on stroke care delivery and outcomes.

5.2 CAN THE ELEMENTS OF PRACTICE BE USED TO DIFFERENTIATE DIFFERENT WORKING PRACTICES?

In this discussion so far, the term "joint working" has been predominantly used to describe interactions between staff at the study sites. The terms "teams" and "teamworking" have been used specifically to discuss staff perceptions of their joint working, and "team process" has been used to describe the formation and maintenance of relationships between staff in regular contact.

The second research question concerned the need to explore and clarify the use of different terminology that is currently used in the research literature, and in policy documents to endorse joint working, and the need to explore the potential for different terms to describe different working practices. The findings from this study will now be discussed in relation to this need for clarification in terminology, suggesting how the framework of practice that has evolved from the

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data may be helpful in answering this second research question regarding the meaning of joint working.

The literature review highlighted the lack of clarity regarding usage of terms describing healthcare professional joint working practice. Examination of the data has revealed the complexity of joint working practice, and the number of factors which impact upon it, with the study identifying twenty-six key elements within the areas of the organisation, team process, communication, professionalism, the individual, and the service user. Examination of the data suggests that it is possible to use the elements of practice identified, to distinguish two different forms of working practice occurring at the study sites. These two forms of working can be termed teamworking and interprofessional networks.

The three cases studied appeared initially to fulfil the requirements for classification as each being a team, however, closer examination of the data relating specifically to team process factors from observation, visual imagery and interviews calls this into question, and suggests that a second form of joint working practice was occurring at these sites, which could be termed an interprofessional network (as described by Øvreitveit, 1997b).

As has been outlined previously, the large number of professions that could be called upon to advise/provide input at the sites for an individual patient could make identification of team membership complex. This is illustrated well by the

variation amongst individuals at a single site regarding who they would include as a team member exhibited by the visual image data (see for example Figure 2).

The literature review also outlined the need for a readily identifiable team membership, and discussed the impact of team size on team process. Poulton and West (1997) for example reported a negative correlation between participation and team size, with interaction and co-operation decreasing after fourteen team members. In this study, teams could have up to fifty people forming the perceived membership. This creates a group of people that the literature would consider too large to enable crucial team processes to operate, and together with a lack of consistency of membership created by organisational conditions (discussed in previous section) seemed to make it impossible to sustain team functioning, leading to sites, which were not functioning as teams, but where there were teams operating as sub-groups, with two forms of joint working being present, which this study proposes are teamworking and interprofessional networks.

Thus the data suggests, that although all the study sites seemed to fulfil the requirements of a team in terms of having a social relationship, they were comprised of individuals working in various relationships with each other, with same profession/allied health professionals having a closer relationship with each other than with other individuals. This was described in the previous findings section as being "teams with a team", or subgroups operating within the main staff group. Perhaps this formation of different relationships was an inevitable response to the team having such large membership as described above, or a

response to the organisational conditions described in the previous section. This notion of "teams within teams" may also be related to professional versus team identity, encouraging different forms of working relationships between staff at the sites.

Examination of the data relating to goal/purpose also indicates that in this important feature of team process, the clarity and sharing of task objectives was problematic in the sites studied. It was possible to distinguish different types of goals amongst staff in the same team, such as profession-specific goals, goals relating to quality of care provided and goals relating to patient outcome. Dhillon (2005) describes shared goals as "social glue", and it was apparent that in the sites studied it was the individuals who discussed and implemented goals together who were in closer working relationships with each other. There were examples of either single profession grouping, or allied health profession grouping to formulate goals, further suggesting that all the sites did not fulfil the definition of team functioning, but contained two different types of working relationships, which could be termed teamworking and interprofessional networks.

Finally, another area of team process that was problematic in the sites studied was the notion of leadership. As mentioned previously, there was surprisingly little data that related to this aspect in two of the three sites, indicating that it was not an issue of contention. As an important indicator of joint working however, it is perhaps of significance that it was not highlighted by study participants as a key element of working practice at these two sites. It was difficult to discern at

two of the study sites who was considered to be the leader of the team, with evidence that individual professions had their own lead for professional/clinical matters, and complex mechanisms of management structure. This uni-profession leadership may be a contributing factor to the description of teams within the team at the study sites, with the lack of a clear site leader indicating that there were multiple teams, rather than a single team operating. The site that did have an identified leader had team processes evident, and was the one site where there were no sub-groups operating.

The data thus suggests that rather than all the study sites being "a team", two different forms of working practice were occurring, which it is argued can be termed teamworking and interprofessional networks. As proposed above, although all the sites at first appeared to be operating as a team, further analysis of four key aspects of team process, namely, size, relationship, goal/purpose, and leadership, suggests that there *were* teams operating, but at a sub-level below the whole site for two of the three cases studied, with only one site meeting the requirements for whole site team functioning.

Where there were several staff of the same profession they could be described as operating as a team (for example a team of nurses, a team of physiotherapists), or where staff groups were smaller they could form teams with other similar professions (for example a team of allied health professions), but the lack of shared objectives, defined leadership, defined membership, close social processes, and large number meant that two of three sites, although believing themselves to be a team did not in practice function as one.

Thus, the study suggests that teamworking, was present at only one of the sites investigated, and has used the term "interprofessional network" to describe the second form of working in evidence. It is argued that the multi-faceted difficulties that could be associated with stroke, requiring input from a vast array of different individual practitioners (termed "associates" by Øvrietveit, 1997b) entering and leaving the core group meant that whole site teamworking could not be supported. Payne (2000) argues that this demonstrates the need for a modern vision of teamwork that he terms "open teamwork", where close relationships in the team are the basis for team members networking with others outside the team.

In terms of the discussion in the literature review regarding the use of different terminology, the conclusion that two different forms of working were distinguishable in this study, supports the argument that different types of joint practice, which may be called teamworking and interprofessional working, can be differentiated. Teamworking being the closer working relationship, and interprofessional network working being a less-close relationship amongst professional colleagues who are providing care to the same patients. This interpretation of the data echoes Barr's (2002) description of interprofessional working as being "broader" than teamworking. This study suggests that "broader" refers to interprofessional working describing a less close working relationship than teamworking. Teamwork specifically has the features of team process, but interprofessional networks are about working effectively with others who are not part of the team.

The team process data suggests that the elements which identify teamworking as a discrete entity from interprofessional networks are: similarity of organisational factors; regular contact between members; identification of team membership amongst members; perceived support for each other; identifiable leadership; established group norms; and shared identification/planning of goals. These factors were present for one site, suggesting that this site operated as a team, but not at a whole site level for the other two locations. A model illustrating how elements of practice can be used to distinguish between teamworking and interprofessional networks is illustrated in Figure 6.

Figure 6. Model showing the elements of interprofessional networks versus teamworking.

Interprofessional network

- Ratification of decisions
- Formal communication systems
- Knowledge exchange

Teamworking
- Consistency of: organisational conditions, location, management
- Identified membership
- Frequent contact
- Group support
- Goal planning forum
- Identified leadership
- Group norms exist
- Decision-making forum
- Informal communication systems
- Knowledge sharing leading to elements of role blurring

The data relating to communication also offers the potential for identification of different working practices. The data describes different types of communication systems operating within the sites, with examples of formal and informal

mechanisms. Although it is the formal mechanisms, which are the espoused means of communication (and also decision-making), the data suggests that informal systems operating were significant. It was often these informal systems, which operated amongst the teams, and formal mechanisms that operated on the site as a whole, with evidence of "pre-meeting meetings", and the significance of location of staff, such as shared offices in defining who would be undertaking informal exchanges.

The formal communication systems operated as a means of passing information between individuals, often necessary to ensure that professionals who did not form part of the teams were informed. These formal communications felt at times as a kind of "rubber stamping", documentation exercise, and an indicator of interprofessional networks unlike the informal communication systems of teamworking. This interpretation of the data is supported by Lewin and Reeves (2006), who describe "backstage", and "front stage" interactions on hospital wards, with the "front stage" interactions being the formal communications amongst professionals.

This interpretation is also supported by Gibbon (1999) who studied stroke team conferences. As in this study, he describes the team conference as being identified by team members as the formal channel of exchange of information and decision-making, but observed that the "seeming lack of clinical decision-making at team conferences is striking". Gibbon suggested that in the two teams he studied, decisions were seemingly established outside the team conference, with the meeting "serving to confirm and disseminate the decision rather than

make it". This has strong echoes of a field note comment made after a team meeting observed during this study:

> "Afterwards I wondered what the objective was that the meeting had fulfilled, apart from the medic being informed. The therapists and nurses were aware of the goals for each patient, it did help to clarify management in terms of meetings for review and discharge, and referral for #, but could all this have been done by email or personal contact." Document 'Field notes 4', section 0 paragraph 3.

These elements of communication and decision-making feature in the proposed model of working practice illustrated in Figure 6, as indicators of two different forms of working practice.

The final element that is included in the model as distinguishing interprofessional networks from teamworking, is associated with professional knowledge. The literature review discussed the need for team knowledge and shared mental models, and described the distinction between knowledge transfer and knowledge sharing (Nelson and Cooprider, 1996). The data highlighted the importance of knowledge and skills transfer and sharing amongst staff, with evidence of this leading to some elements of role blurring amongst the sub-group team members who were experienced practitioners (for example some blurring of knowledge and skills amongst the allied health professions).

Yen et al. (2006) emphasise that shared mental models "are the key to supporting many interactions within a team that lead to its effectiveness and efficiency". They suggest that higher functioning teams have a shared mental model of what other team members are doing, maintaining "mutual awareness", which aids effective collaboration. They assert that shared mental models can be measured by the degree of overlap or consistency in knowledge and beliefs of team

members. Cannon-Bowers and Salas (2001) caution against knowledge similarity in a team, arguing that where tasks are complex team member knowledge is specialised and distributed, forcing team members to co-ordinate since task success depends on knowledge of many team members. Cooke et al. (2000) suggest that knowledge sharing helps team members to co-ordinate implicitly, allowing individuals to make predictions about the behaviour of fellow team members, based on a shared understanding of team structures such as different roles in a team. This seems to have links with Systems Theory, which this study has emphasised is an important model for viewing healthcare delivery, as within the "interprofessional system" it is necessary to understand and evaluate ones own and others' contribution to the system by acquiring a shared understanding. The data relating to knowledge/skills transfer in relation to the nursing profession however, seems at odds with proposing that knowledge/skills transfer was most apparent amongst the sub-group team members. Nurses seemed to be a sub-group team, distinct from the allied health professions, yet acquired knowledge and skills from all other professions. As the unique provider of 24 hour care in the acute sites, and as provider of basic needs care, nurses were required to incorporate many elements of other profession knowledge/skills in their role. This knowledge transfer was distinct from knowledge sharing, and did not seem to lead to role blurring between nursing and other professional groups, as there was not depth of knowledge, an important marker of role boundaries (discussed in the previous section).

For experienced practitioners within a sub-group team such as an allied health professions team or an occupational therapy and physiotherapy team however

knowledge/skills sharing could lead to some blurring of boundaries, and has therefore been included as a potential distinguishing factor between teamworking and interprofessional working, as well-developed team process factors seemed to be a necessary prerequisite for role blurring.

Having argued that it is possible to distinguish between interprofessional networks and teamworking as different practices, the question then remains regarding whether they operate as a continuum or as discrete entities. The study has suggested that the perceived difference between professions was in terms of depth of knowledge rather than having a discrete body of knowledge, with knowledge and skills sharing being a core feature of team functioning and also being perceived as a key benefit. As mentioned in the previous section, the linking of professional role with depth of knowledge and skills has implications for how junior members might function.

The data suggests that the ability to work with colleagues does change over time, with recently qualified staff seeking support from their own profession colleagues rather than other professions. The data suggests that junior staff function at an interprofessional network level, (where there is knowledge transfer, ratification of decisions and formal communication systems) but not at a team level with other professions where there is knowledge sharing and role blurring, goal planning amongst different professions, team support and informal communication systems. It may be that the more formal operation of interprofessional networks is of benefit to junior staff, as providing clearer systems for functioning within, and as individuals become more experienced

they are able to deal with the more challenging and complex teamworking practice. This interpretation echoes work by van der Gaag and Anderson (2005) who support a continuum of practice from a technical rational approach to professional artistry types of practice. They describe that in this continuum of practice newly qualified practitioners "are more comfortable at the medical/expert/profession-led end" (van der Gaag and Anderson, 2005 p.4).

If, as this study has proposed, these teamworking skills develop with experience there can be considered to be a continuum of joint working practice. However, whereas authors such as Forbes and Fitzsimmons (1993) and Miller et al. (2001) view interprofessional practice as the end of the continuum, this study suggests that it is teamworking that forms the most advanced point. The perception of study participants was that practitioners need to be secure in their own professional knowledge and skills, before building upon these to acquire increasing skills of working with others. This finding suggests that perhaps practitioner development may be considered to be a stepped model rather than a continuum, as new knowledge and skills are built upon already existing knowledge and skills, rather than a practitioner moving on from one stage to the next. See Figure 7.

Figure 7. Progression from interprofessional working to teamworking.

Teamworking with other professionals	Experienced practitioner
Interprofessional working	↑
Knowledge and skills of own profession	Entry level
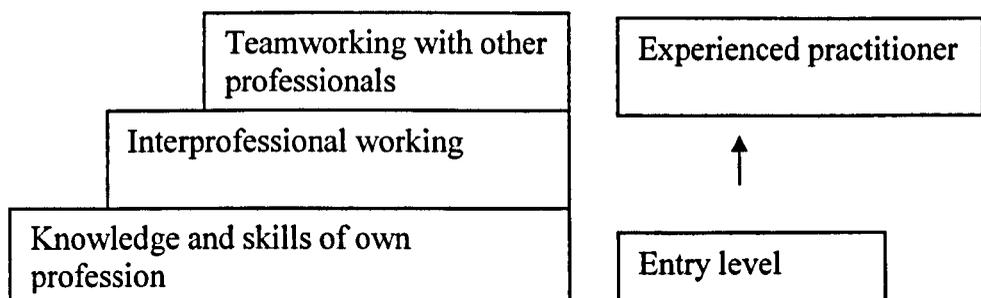
In conclusion, in response to the second of the research questions, the data suggests that it is possible to distinguish between interprofessional networks and teamworking as separate joint working practices, supporting the work of writers such as Loxley (1997), Davies (2000), Nolan (1995), and Wilson and Pirrie (1996). However in contrast to these writers, who view interprofessional as the "gold standard", where there is greater interaction and blurring of boundaries, this study suggests that it is teamworking that is the closer working relationship, achieved by advanced practitioners, where depth of knowledge and skills sharing, informal communication, optimum number, and team process systems lead to a close working relationship which is distinguishable from the network relationship of interprofessional working.

The study describes client care at two of the sites as being provided by an interprofessional network of professionals, who used formal communication systems to transfer information and make broad decisions regarding service delivery (such as when involvement is required of external agencies to the group, and decisions regarding transfer and discharge). It also describes a number of teams functioning, being formed amongst sub groups of these professionals, who use informal communication systems, and make decisions relating to the specifics of client care, such as goal planning, and intervention. The study describes one site as operating as a team, with organisational conditions more supportive, team process factors present, informal communication systems, and professionalism factors in place.

Although all the sites believed that they were operating as a team, the reality was that a network of professionals existed at two of them, and that teamworking operated only at one site and amongst sub-groups at the other two. This finding supports writers such as Loxley (1997), Enderby (2002), and Payne (2000) who argued that teamworking is a commonly used and "feel good" word, which is not always representative of reality. It suggests the need for studies describing and evaluating working practice to use different terminology to apply to different forms of practice if links between practice and outcome are to be clarified. The importance of the elements of practice identified in the previous section, in distinguishing between different types of practice also further confirms the need for studies to more accurately describe and differentiate between these elements of practice.

5.3 WHAT ARE STAFF PERCEPTIONS OF BENEFITS OR LOSSES ASSOCIATED WITH JOINT WORKING?

The data describes staff concerns regarding the time taken up by joint working, echoing the work of Atwal (2004) who found that lack of time was the biggest barrier to joint working in healthcare. Staff reported making the difficult choice between patient care time and joint working time. The greatest factor in this decision-making was the individual's perception of the benefits of joint working. It is important to note that it was the time taken up by factors that this study associates with "interprofessional network activities", such as meetings to transfer information rather than factors which this study associates with "teamworking activities", such as knowledge sharing, that expended time. It is also important to note that organisational factors highlighted throughout this

study, such as location of staff, will have a significant impact on time availability for an individual.

Staff identified the benefits of working together in terms of support, the sharing of knowledge and information, and a reduction in individual responsibility and decision-making. The sharing of knowledge and information was described as being of benefit both to staff themselves and to patient care. Staff described the benefits to themselves as being the gaining of a more holistic view of a person, which in turn enabled them to better provide care, supporting the work of Hoopes and Postrel (1999) and Nelson and Cooprider (1996) who linked shared knowledge to increased performance. This more holistic view of patients could also be linked to a shift from a medical model view of care to a more rehabilitative model or more patient-centred care, a change in viewpoint often associated with joint working (discussed further below).

Staff, in addition identified the benefits to patient care in terms of the avoidance of duplication or incompatibility of care, suggesting service delivery benefits; thus supporting authors such as Wilson and Pirrie (1996) and Lavin et al. (2001). Staff talked about the faster processing of referrals, so care provided more speedily. This factor may be especially important for stroke care outcomes as the evidence suggests that early rehabilitation produces better outcomes (Department of Health, 2005b). This suggestion from the data that care may be provided more speedily in joint working, may highlight an important benefit particularly for the field of stroke care, and may add to the evidence base linking improved service delivery to improved patient outcomes in stroke rehabilitation.

The finding that there was a perceived reduction in individual responsibility and decision-making in joint working, offers a less straightforward discussion of possible benefits and losses. Although perceived by the staff as a benefit, the reduction in individual responsibility could potentially be a loss. Loxley (1997) raises the issue of accountability in collaborative working, with the potential for difficulty in getting redress for unsatisfactory care, for confusion in roles, and the masking of difference. Ovreitveit (1997a) identifies collective responsibility as the sign of a fully integrated team, but warns that this does not mean that individual members are accountable as a group rather than individually professionally accountable. Sidhom and Poulsen (2006) highlight that there is a need for a greater awareness of individual clinician responsibility in multi-disciplinary team meeting decisions, with a need for clinicians to recognise that the medico-legal responsibility of individual duty of care needs to be maintained in joint decision-making.

The literature review section discussing professional role, described potential difficulties of role redevelopment in terms of accountability and legal problems. The background to the study section also described the failures in care that contributed to the call for improved joint working in the UK. It is important to note that in the Bristol Infirmary Inquiry report (Bristol Royal Infirmary, 2001), there is a recommendation for clarity in "identification of responsibilities of members of the team" to avoid "uncertainty in how to get things done" (Bristol Royal Infirmary, 2001). The Victoria Climbie Inquiry report also describes a lack of accountability and calls for a "clear process of decision-making and

monitoring of performance" to avoid "organisational confusion and buck passing" (Lord Laming/Great Britain Home Office, 2003, paragraph 17.86).

In pre-qualification training, the importance of individuals developing their own professional role is being increasingly recognised (see for example Molyneux 2001). It is also argued that an understanding of another professional's role is more difficult if the perception of a practitioner's own role is unclear (Kilminster et al. 2004, Ponzer et al. 2004). Studies both within and outside healthcare have consistently shown that an understanding of each team member's role is central to joint working (see for example Kilminster et al. 2004, Pethybridge 2004, Bateman et al. 2003, McCallin 2001a). Sheard and Kakabadse (2002) also identified "agreed and understood roles" to be central to an effective team. This research may suggest that role redefinition needs to be carefully considered, as there may be issues of reduced professional identity and clear responsibilities.

This is important in light of the previous discussion regarding a difference between the two working practices of teamworking and interprofessional networks. If, as this study suggests, two different working practices can be identified, it may be that within the closer working relationship of teamworking that some role blurring and redefinition is possible amongst senior practitioners (which this study did find), but within an interprofessional network form of working, that role blurring or lack of clarity could be problematic, as a lack of shared knowledge could have worrying consequences. Findings from this study suggest that although staff themselves perceive there to be a benefit in a

reduction of individual responsibility, a lack of clearly defined professional roles may be of concern.

Similarly, the perception of shared decision-making as being beneficial, could potentially also be a loss. The teamworking literature in fields outside of healthcare describes the phenomenon of "risky shift" (West and Poulton, 1997), where groups make more extreme decisions than individual members, and the phenomenon of "production blocking" (West, 1994) where individuals may contribute less to a group. If these phenomena occur in a healthcare context, this could be a detrimental effect of joint working.

Whilst this study is not able to provide conclusions regarding the quality of the joint decisions made, as quality of care was outside of its remit, the data does highlight the need for individual practitioners to have confidence in communication. This finding may suggest that the decision-making process at the study sites had the potential for blocking of individual contributions, where individual staff may not have possessed the individual personality qualities to "hold their own" in a multidisciplinary meeting, and where at the hospital sites medicine tended to have a dominant position regarding decision-making. However, it could also be argued that the data as discussed previously suggests that the formal multidisciplinary meetings, although declared by participants to be the decision-making forum, were instead a decision ratification forum. Thus, it may be that the ability of individual staff to engage in informal communications with other professionals outside these formal meetings may in

fact have the greater significance in terms of ensuring all contributions to a decision are heard.

Shared decision-making may be viewed as a positive factor, as studies have consistently indicated that patient safety (a reduction in clinical errors) can be associated with effective joint working (Schmitt and Bleakley, 2006, Alonso et al., 2006). Staff in this study certainly perceived that "better decisions" were made as a result of joint decision-making. Glavin (2006) highlights that medical error is one of the ten leading causes of death in Western medicine. He describes errors operating at the individual level, and the systems level, but also emphasises the importance of generating and maintaining correct group mental models for patient safety. Alonso et al. (2006) also support the linking of joint working with improved patient safety. They describe 70 percent of all medical errors as being attributable to breakdowns in interactions in health care teams, highlighting information exchange and consultation with others as being two of the core skills needed in joint working to avoid medical errors.

A further benefit of joint working described by some staff in the acute setting was that of earlier discharge for patients. It is important to note that staff also mentioned that earlier discharge was not always a better outcome, but that it should be timely discharge. During the period of this study there were organisational drivers regarding maximum in-patient episodes, which staff reported was having an influence on their work, as patients were being discharged as soon as possible. During the period of data collection there was also considerable media and government-led attention regarding hospital-

acquired infections that was also reported by staff to be contributing to early discharge. As well as earlier discharge, staff also described greater efficiency of service provision, more cohesive provision, and also a higher level of service provision (although this could be purely linked to staffing levels) associated with joint working.

5.4 HOW ARE JOINT WORKING PRACTICES PERCEIVED BY SERVICE USERS AND STAFF MEMBERS?

Apart from the negative factor of loss of time, staff reported no other losses, and they were highly positive regarding joint working. Payne (2000) declares that thinking about joint working causes the focus to be on professionals and their interactions, yet services need to be responsive to the service user. He also argues that use of the term "interprofessional" to describe joint working implies the exclusion of service users (Payne, 2000).

The findings section presented data relating to the role of the service user at the study sites, describing disparity amongst staff as to whether they considered that "the team" included the service user or not, which was contrasted with the frequent mention of "patient-centred care". Abreu et al. (2002) in their study of people with brain injury similarly found that there was a difference between the perception of staff and the reality, regarding the role of the service user. Kennedy (2006) contends that all change within healthcare must be to advance a more patient-centred system of care. He argues that if healthcare provision is to improve, then the culture of professionalism must change from the patient being

in the professional's power to a situation where patients are empowered and are equal partners in care.

The service user role is important to consider as this study has argued the need for the development of "team process factors" if true teamworking is to be fostered rather than interprofessional networks. This leads to the question however, that in the development of a close-knit team where there are social processes operating amongst staff, where is the service user and family positioned? This study suggests that the potential tension between patient-centred care and teamworking needs to be addressed in the drive towards increased joint working.

The data suggests an increasing role of the patient in decision-making once discharged from hospital care, in particular in relation to goal planning. All the teams seemed to be making efforts to involve patients in their care, identifying goals and keeping patients informed, although at the hospital sites there was evidence that policy drivers were a strong influence in discharge decision-making.

The study did not uncover differences in patient satisfaction with care in relation to hospital versus community teams that the Sentinel Audit (Royal College of Physicians, 2006) would suggest. The service user experience of the care provided by staff at the sites investigated was generally positive. During the interviews the researcher had endeavoured to elicit views of joint working practice from the patient participants. In the acute setting service users wanted to

be spoken to respectfully, wanted their needs to be met, and raised concerns where there was a reduction or cessation of therapy intervention. They were sometimes unclear regarding which professional did what, suggesting that it perhaps was not important to them who it was, so long as their needs were met. This suggestion echoes the work of Biggs (1993) who concluded that "the client is not so much concerned with the issues of multidisciplinary demarcation as receiving a service that is both efficient and effective." There was some data suggesting that service users enjoyed receiving care from a number of different people, expressing concern that if one person provided all the care that they might not get on with them.

The number of patient interviews was smaller than the number of staff interviews in this investigation, and therefore less data was available to be reported in the study findings. It is interesting to note however that the patient interviews were often longer than the staff interviews, as the patients were less constrained by working pressures and wished to talk to the interviewer at length about their experience of care. Also, in some cases because of communication difficulties, eliciting and obtaining responses was a longer process. However, these longer interviews tended to have less coded data within them than other forms of data generation, as much information did not concern joint working practice and was therefore not significant for this study. This limited amount of significant information regarding joint working from the patient interviews may be explained in part by a recent study investigating patients' views of nurses' competence (Calman, 2006). This work found that the "experience of being a patient" could not be separated from judging care. Calman reported that

"patients tended to tell stories about being a patient" rather than giving an account of the nursing care, a finding that is echoed by this study which endeavoured to seek information from patients regarding joint working. The patient interviews will be discussed further in the evaluation of methodology section.

An area of interest that emerged from the data in regard to staff and service user perceptions of joint working was the finding that staff perceived joint working in stroke care as being different from other areas of healthcare. Staff linked this perception of difference to the length of stay following a stroke in acute settings, and to the specialist nature of stroke care. There was also a perception that the model of healthcare that was predominant for this group of service users either was, or should be, a rehabilitative model rather than a medical model. There was evidence of some perceived conflict between professional groups or individuals who approached care of stroke from a medical perspective and those who did not. This was a criticism made of the medical profession mostly, but there is also evidence in the data that nursing was also viewed as too medical by the allied health professionals. This finding is supported by Wittenberg-Lyles (2005) who found a similar tension between "biomedical" and "psychosocial" philosophies in her study of multidisciplinary team meetings.

This perception of staff that there was a distinction between models of care is significant as it suggests that joint working may be associated with a particular model of healthcare. Staff identified that medical and rehabilitative models both

"had their place" in care provision, but that different models were required for different client groups and different settings.

It could be argued therefore that as the particular client group will impact on the way that professionals work together (with different working practices needed in different contexts), so joint working may not be a unitary phenomenon and may change from context to context. As the less close working relationship, therefore potentially less context driven, it is possible that it is interprofessional network working that remains constant across care groups and it is teamworking that changes according to client care group and context.

The data described in relation to the organisation highlighted how important background factors can be in influencing the way that staff function, and participants reported that community and hospital-based sites presented different challenges to joint working. One of the key differences highlighted by participants was in regard to the role of the service user in hospital based versus community based settings, in particular the difference in goal planning, which became more patient-led in community services. Hugman (2003) supports this argument that joint working is different in different contexts. He noted differences in practice between community teams and hospital-based teams. Payne (2000 p.8) also highlighted that "the characteristics of teamwork depend on the factors affecting the social situation in which the team works", suggesting that further work is needed to determine if the teamworking elements that this study has identified are transferable to other client care groups.

Having discussed the study findings and considered these findings in relation to research questions, this section will now move on to an evaluation of the study design, reviewing the methodology and data analysis strategy.

5.5 REVIEW OF METHODOLOGY AND DATA ANALYSIS STRATEGY

The study design section explored the rationale for utilising a qualitative approach, highlighting the study aim of examining naturally occurring data in the form of words and visual images to derive meanings and explanations of a complex situation. The qualitative multiple case study design was successful in yielding depth of data for each of the study sites, and enabled comparison and contrast (Bechofer and Paterson, 2000) to be drawn between the three individual case investigations. The methods employed of observation, interview and visual image produced a large volume of data for analysis, and enabled multiple sources of data, or a "chain of evidence" (Yin, 1994) to be examined. The use of these methods of data collection in the study will now be reviewed.

i) Observation

The periods of fieldwork observation were a challenging part of the study for the researcher, who had no previous experience of this form of data gathering in research. The reflective diary completed throughout the study contains references in the early stage to the challenges of the observation method, for example:

> "Another visit to the unit, seem to be very slow getting anywhere." (Document 'thoughts and ideas' Section 0, paragraph 8).

> "Finding a place in the unit is a difficult one.....a lot of hanging about waiting for meetings etc."(Document 'thoughts and ideas' Section 0, paragraph 14).

> "I wonder whether the therapists are getting fed up with me sitting in." (Document 'thoughts and ideas' section 0, paragraph 8).

The feelings described here echo the work of Morse and Richards (2002) who highlighted the stages and phases of ethnography, with the first phase "getting in" being a period of "finding a role and fitting in...the researcher feels awkward and self-conscious" and for the need to be able to "tolerate feeling out of place" (Morse and Richards, 2002, p.51). By the fifth visit to the first site the diary records:

> "Good day today, felt a lot more comfortable on the unit." (Document 'thoughts and ideas' Section 0, paragraph 17).

> "After the meeting had a good chat with the physio who had been in the meeting, she seemed a lot less defensive than previously." (Document 'thoughts and ideas' Section 0, paragraph 17).

The data gathering had reached the second phase of ethnography where "the researcher becomes better acquainted with the routines and the setting and the participants become more comfortable with the researcher" (Morse and Richards, 2002, p.51).

- **The role of the researcher**

The methodology section explored the role of the researcher, and the need to make decisions regarding the level of participation in the setting and the need to consider that role that the researcher will adopt (Rossman and Rallis, 2003). As described in the methodology section, the researcher deliberately chose a clinical area outside of her expertise for the study. During the study this did seem to facilitate the interaction between staff and the researcher, as staff seemed reassured that it was not their clinical expertise that was under scrutiny and sought to clarify this at pre-study meetings. This decision however resulted in the researcher being only as a non-participating observer, which may have

extended the first stage (Morse and Richards, 2002) feelings of awkwardness illustrated by diary comments:

> "Feels at last as if getting somewhere....worth bearing in mind that need to keep popping in and out for first few weeks and allow longer time after three or four weeks. It is probably unsurprising that it takes a while for staff to get used to you being there, they don't know who you are and what you are doing with the data, probably takes a while to be trusted". (Document 'thoughts and ideas' Section 0, paragraph 17).

The experience of the researcher as a clinician in healthcare seemed important in the establishment of the relationship between the researcher and participants. Knowledge of jargon and technical terms seemed to facilitate the informal conversations during the data gathering, and also mutual recognition of the demands and complexities of practice may have been of significance in establishment of the researcher within the setting.

In the initial stage of data gathering it seemed that the selection of where to site oneself whilst at the site was an important one. At the first site studied the researcher had been allocated a desk to use as a base, a seemingly very helpful move on the part of the host site. However the researcher began to feel that although the location of the desk was in an office space with staff frequently passing through that it not an ideal site as it was away from the main ward and was the designated "management office" and that:

> "Maybe sitting in the side office and word processing doesn't help as they are probably wondering what I am writing." (Document 'thoughts and ideas' Section 0, paragraph 17).

For the second study site the diary records:

> "Opposite the nurses station so can see comings and goings. Not wanting to make the same mistake as last time, sitting in an office." (Document 'thoughts and ideas' Section 0, paragraph 30).

The observation methodology also requires the researcher to be very proactive in establishing relationships and seeking out information such as times of meetings and locations of offices:

> "Introduced myself to everyone coming in and got chatting to quite a few of them." (Document 'thoughts and ideas' Section 0, paragraph 30).

> "Seem to have different places they (staff) can be – upstairs on the x or downstairs in the x, also there is a x room, maybe they are sitting there, need to go and check it out." (Document 'thoughts and ideas' Section 0, paragraph 33).

A key area of concern for an observational method concerns the time sampling of observation periods and the representativeness of periods spent in the setting. Table 8 details the periods spent at each study site.

Table 8. Time periods of the studies.

	Study one	Study two	Study three
Monday 8-12	5 hours	3 hours	6 hours
Monday 12-6	1 hour	4 hours	7 hours
Tuesday 8-12	9 hours	4 hours	1 hour
Tuesday 12-6	4 hours	1.5 hours	2 hours
Wednesday 8-12	12 hours	5 hours	7 hours
Wednesday 12-6	7 hours	2 hours	8 hours
Thursday 8-12	3 hours	6 hours	3 hours
Thursday 12-6	0	5 hours	3 hours
Friday 8-12	0	2 hours	2 hours
Friday 12-6	4 hours	3 hours	3 hours
Saturday/Sunday	0	0	0
Total hours	45	33.5	42
Time period	30 days	19 days	26 days

Prior to carrying out the study, the researcher had expected that evening/night observations and weekend observations would be required in order to ensure completeness of time sampling. As can be seen from the above table however, time sampling was limited to a "normal working-week" time frame. It became apparent in the initial data gathering at each of the sites that there was rarely or no joint working occurring outside of "normal" working hours. At the acute sites the nurses were the only staff present during evenings and weekends except for rare occasions where doctors were called to an emergency. At the community site all staff were employed during normal working hours. This restriction of time sampling to weekday and daytime only could be seen as a limiting factor to the study, however the data is supportive that these observation times offered a representative sample of joint working.

In the study design it had been anticipated that data gathering would be carried out within a two-week time frame, whereby the first week would be establishing key time periods to be sampled in the second week (see study design section). In reality this proved to be overly optimistic, with the periods over which a study site was visited extending beyond two weeks. This lengthening of the data-gathering period was the result of changing staff working patterns, annual leave, and limited availability for interview. Also, the result of limited patient availability for interview, due to illness, relatives visiting, and in particular at the acute sites, patients receiving treatment. The observation period was also extended in order to observe significant interactions between professionals such as case conferences, which occurred less frequently than once a week, and also to

include a number of staff meetings for each site, as they could vary in format depending on the individuals present.

Although adding to the researcher time, it is believed that restricting time on each site to a pre-determined time frame would have considerably reduced the completeness of the data. It is believed that the time periods selected for each site were successful in providing a representation of typical working practice at the site. Data gathering at each site was concluded when the researcher believed that "saturation" (Glaser and Strauss, 1967) had been reached, and further study added only "bulk to the data" (Glaser and Strauss, 1967).

The taking of field notes was an area of potential complexity for the observation method. The researcher adopted the advice of Pope and Mays (2000) and kept "field notes" and a separate "diary", one recording descriptions of observations made and the other recording comments and reflections. The convention recommended by Strauss and Corbin (1990) of quotation marks for exact recall, apostrophes for paraphrasing and no marks for recollection was adopted. Field notes were written as close as possible to the situation with use of a notebook and a lap top computer at the study sites, although as highlighted above the use of a lap top to record information although convenient and quick was noted in the diary as a potential source of barrier between researcher and participants:

> "Maybe sitting in a side office and word processing doesn't help as they probably wonder what I am writing." (Document 'Thoughts and ideas' section 0, paragraph 17).

Field notes were re-read and added to outside of the study site at the conclusion of each visit, frequently in the car park, while data was still recent in the researchers mind.

ii) Interviews

- **Staff interviews**

Interviews were carried out with a sample of staff and patients (service users) at each of the study sites. The methodology section discussed the sampling strategy for selection of patients and staff for interview. The selection of the patients determined which of the staff were sampled, as staff involved with the patients chosen would be interviewed. This provided a strategy for the staff sampling in the study design, although in reality proved to be less straightforward than was predicted as for some staff there was considerable rotation between patients, and all the staff at the site could be considered to be involved with a single patient. It was therefore necessary to apply additional sampling strategies during the data gathering. Numbers of staff at the acute site were large (specific numbers will not be given as it is potentially identifying information), particularly for the nursing profession, and within the scope and resources of the study it was not possible to interview all staff. Staff were therefore selected on the principle of "maximum variety sampling" (Morse, 1998), seeking representation from different professional groups, staff with different lengths of professional practice, and staff of different levels of seniority. See Table 4 for breakdown of the staff interviewed for the study.

As above, in relation to the observation method, the interviews proved challenging in terms of establishing relationships with staff. It was found that establishing a good relationship was important in facilitating the process of interview selection. All staff had consented to participating in the study, but as the diary records:

"A real test of patience, staff very busy and getting them to carry out individual interviews is a struggle, say they are willing, but difficult getting them to actually commit to a time and day." (Document 'Thoughts and ideas' Section 0, paragraph 14).

"Maybe I should be being more proactive in asking therapists to take part in interviews, perhaps leave dates and times – worth a try." (Document 'thoughts and ideas' Section 0, paragraph 8).

The methodology section discussed the decision to use a semi-structured interview format with pre-determined topics. The interview format had been piloted prior to the main study, and ethics approval had required the establishment of a prior interview schedule. The diary highlights the need to maintain flexibility within the approved interview schedule, rather than having a pre-determined structured set of questions that would be asked:

"Really useful to be able to change the format as going along and finding things out about the unit..if I had decided the questions beforehand not able to modify as going along, already scribbling a lot over the interview topic guide and pulling out questions of greater significance." (Document 'thoughts and ideas', Section 0, paragraph 14).

As data gathering proceeded at each site, the ability to modify the individual interview content to follow up observations made, to check understanding, or to explore individual perceptions and differences in perceptions was an important element of the data gathering, and supported the need for flexibility in design of the interview format if data gathering is to be iterative, a cornerstone of qualitative methods.

Decisions regarding the timing of the individual interviews in the data gathering process was an area highlighted in the research diary:

"Doing the staff interviews seems to break some of the ice, should interviews be done before the observation....is doing observation rather threatening for

the staff. But does getting to know the setting help when doing the interviews?" (Document 'Thoughts and ideas' Section 0, paragraph 37).

At all sites the interviewing began after periods of observation, and continued simultaneously with further observation. This was predominantly linked to the need to have a presence at the site to facilitate the process of interviewee selection and interview timing. As the study had no local investigator, this required the presence of the researcher for periods of time, which were extended to include observation periods. Towards the latter stages of data collection at each study site when the observational stage had been completed, the final interviews were completed by travelling to the site solely for the purpose of carrying out the interview.

The use of interviewing alongside observation for the majority of the data collection proved valuable in resolving researcher questions and issues as they arose, enabling cross-checking of the data and the in-depth exploration that the study sought. The methodology section discussed the debate concerning the use of multiple methods and triangulation in order to achieve greater validity. It is believed that in this study the use of multiple sources of evidence was valuable in providing a holistic view of a complex setting, and when combined with the multiple case studies used was able to provide depth and strength to the conclusions drawn (as advocated by Yin, 1984).

Reeves et al. (2006) also support the use of interview with observational data in studies of healthcare professional's interactions to move beyond reliance on an individual's ability to recall and a "normative picture of action". In this study the

parallel use of both observation and interview was important in uncovering data relating to the informal mechanisms of communication operating at the study sites, with team members espoused views of decision-making described in some interviews not always being borne out by observation. Also observation was helpful in uncovering the mechanisms of teamworking, and the patient role in service delivery, which again could contradict information provided during interviews.

- **Patient/service user interviews**

The interviews with people whose care was being provided by the stroke teams also formed a potentially important source of cross-checking and exploration of the case study sites. The sampling of patients proved challenging at the acute sites as transfer of individuals in and out of the unit could be rapid, and not always predictable, the general health of the person could fluctuate, and the intensive involvement in rehabilitation could make availability for interview unpredictable. At the acute sites there is also some concern recorded in the study diary as to whether the patient interviews were gathering relevant data:

> "Difficult to know if I am going to get what I want from this or whether the fact that the patients are finding it hard to talk about the staff is showing what I want, that …..things like meals and toileting is what concerns them most at the moment." (Document 'thoughts and ideas' Section 0, paragraph 24).

> "Not convinced that interviews with patients are yielding that interesting information – is it too early in the process, patient not able to reflect on the care received?" (Document 'thoughts and ideas' Section 0, paragraph 35).

From doubts following these initial interviews, subsequent interviews proved to be more valuable in highlighting similarities and differences in perceptions between staff and patients, and were thus a valuable further source of data for

comparison and depth for the study. However, as described in the previous section, the patient interviews tended to yield less coded data than the other data sources. This could potentially be a weakness in the patient interview schedule, interviewer skills, or reflect a reluctance for patients to give an opinion regarding staff who were still caring for them (Calman, 2006). Due to the ethical approval process, it was not possible to pilot the patient interviews before use, or to make significant changes to the format once the study was underway, which was a source of constraint.

Unlike many studies, potential participants with communication difficulties were not excluded, as it was hoped that the researcher's experience would facilitate their contribution. In one instance (patient interview d & e) an interview was conducted with two patient participants simultaneously at their request, as they were able to aid each other's contributions by prompting each other and some interpreting of unclear responses. Having a friend present seemed to reduce the pressure on each individual to make a response, and although this approach had not been planned it worked well in this instance. During the study, in addition to severity of impairment, factors of age and gender were considered as possibly significant to the sampling process. Table 5 details the breakdown of participants by severity, age and gender. As can be seen the study was able to recruit participants across a spread of ages and impairment, although the smallest group of participants was from the severe impairment group which may be due to these people being less stable from a health perspective (and thus not agreed by staff to be potential participants), or there being less individuals within the stroke teams studied. For some of the patients who were interviewed at home, their spouse

was able to be present during the interview, which provided additional valuable information on perceptions of experiences.

iii) Visual image data

In the study design it had been proposed to have two forms of visual image data, a diagram of teamworking and a contact diary. Both these forms of data proved challenging to use, and as noted previously, the contact diary was abandoned early in the study, as it proved unworkable at the first study site.

The contact diary was designed to capture data outside of the periods of fieldwork, asking participants to self-record numbers of interactions between themselves and colleagues during a working week. When approached, participants reported that this would not be possible to complete as interactions were happening informally for much of the time and would not be possible to record. The contact diary, unlike the teamworking diagram had not been trialled during the pilot study, as the pilot participants were not practicing clinicians. This was a weakness in design as had the diary been tested, the difficulties with it would have been identified and possible alternatives could have been devised.

As ethical approval had been given in regard to this version of the diagram it was not possible to make revisions without seeking re-approval which was not possible within the timescale as data collection had commenced. The decision was therefore taken to remove this data collection method, and to partially compensate by gathering data relating to contact with other team members in more depth via the individual interviews. It could be argued that the inability of

the team members to identify specific times where they were working with other team members was an indication of close working practice, and the data collected relating to informal communication may support this.

This removal of one of the sources of data collection has implications in terms of data completeness and "truth value" (Lincoln and Guba, 1985), which will be further explored in the review of methodological rigour section.

The second form of visual image data was the teamworking diagram, which required participants to draw a diagram of how they saw the team. The drawing had successfully been completed by participants in the pilot study, but proved more challenging for many of the main study participants. There was some reluctance to commit an image to paper, which could possibly have been related to concerns regarding confidentiality (a written paper having more permanence than the spoken word). Alternatively some of the participants reported that they had no image of the team, or were poor artists and thus unable to complete the task. Where visual image data was not possible to obtain during the interviews, participants were asked instead to verbally describe their team, enabling the data to be partially gathered via a different route. Although the number of completed diagrams for each study site was small, they were a valuable means of gaining further insight into working practice, and proved important in confirming researcher observations of team process, providing another means of strengthening the data.

iv) Review of data analysis

The methodology section identified the need for clarity in reporting of qualitative data analysis strategies. It also highlighted the recommendation from writers such as Lincoln and Guba (1985) that analysis should begin early in the data collection and continue as a concurrent process. In this study the analysis began during the collection of data from the first study, with extended periods of analysis at the conclusion of the second and third study site data collections. As described earlier, field notes were completed following each visit to the site and word-processed, tape-recorded interviews were word processed, and a research diary was also maintained. The computer-aided qualitative data analysis software NVivo was used to support this entering and storing of the data.

The data gathered and stored was read on a line-by-line basis and coded (or indexed) supported by the NVivo coder. Two of the three types of coding described by Morse and Richards (2002) were used in this first stage of analysis: firstly descriptive coding to record information about the data (stored as document attributes and document properties in NVivo); and secondly, topic coding (stored as node trees in NVivo). The coding of the initial documents used the node tree established in the pilot study as an initial start list (Miles and Huberman, 1984). This framework however was used only as an initial coding tree with additional nodes being added as each new document was coded. When data gathering was completed at the first study site the documents were re-read and nodes re-checked for consistency by removing the coding stripes and re-assigning codes to ensure that the researcher was being consistent with coding.

Following this checking of the coding, material was analysed in more depth by reviewing all data coded to each node, looking for inconsistencies and considering where data could be further grouped together within new nodes, or material coded to different nodes was indistinguishable and should be amalgamated. For example data coded to the two nodes of "power" and "status" was considered and found to be indistinguishable, therefore the nodes were combined, also "communication", which in the pilot framework had child nodes of "good" and "bad" was recognised during the data analysis of having data linked to formal versus informal communication, and also "confidence", an element which had been included within the personality node was associated with communication skills by the participants.

Another example was in regard to the parent node "conflict" which had been established in the pilot framework. Data coded to this node was examined and firstly was moved to a child node within team process as an element of teamworking. The node was re-examined as additional data was added to it and it was found that the data related to conflict was associated with either decision-making or organisational conditions, so the data was recoded within these two nodes. It was also found during the analysis process that the parent nodes were clearer as a vehicle for associated child nodes, rather than having data coded to them, so for example data coded to "organisation" was recoded to one of the child nodes, "organisational conditions", "location", "management" or "acute versus community".

Subsequent study sites followed the same pattern, namely coding individual documents using existing codes, and creating new codes, using the principles of constant comparison (Silverman, 2001). Following completion of subsequent sites, coding of documents from previous sites was revisited in order to check whether emerging codes had an impact on the understanding of previously gained data, and searching for negative instances in the data (Mason, 2002).

A trend that was noticeable during the coding process, was that as the study progressed and data from new sites was added, more data was assigned to codes as the depth of understanding increased, and the coding began to move from topic coding to analytic coding with the creation of additional free nodes. An additional memo document was created within NVivo named as "thoughts and ideas" to capture questions and hunches that occurred during analysis, and to consider the emerging findings in regard to the literature review. The data began to be searched for material (using re-reading of material and the NVivo search capabilities) that supported or countered previous work in the area, moving the analysis from description to interpretation using a pattern matching approach (Gibbs, 2002).

The creation of a beginning framework for the data analysis facilitated coding of the first few documents, and provided a theoretical underpinning for the data gathering and analysis, but the research diary records the potential danger of this approach on one occasion:

> "Have been coding up documents from the second site, am aware of trying to fit information in to coding framework – need to be careful that not being blinkered." (Document 'diary of data analysis' Section 0, paragraph 13).

There was also some consideration of what should be done with the starter codes that had no data associated with them, recorded as comments in the research diary:

> "Is the establishment of a framework the best way to start coding – should I be leaving the unused categories rather than moving them about and reforming them? Not sure if it is useful to use unused categories as negative instances?" (Document 'diary of data analysis' Section 0, paragraph 6).

> "Have already added new nodes in – but I am thinking that to have too many nodes is not helpful, should have perhaps started with fewer and added them in as needed rather than starting with the complete tree." (Document 'diary of data analysis' Section 0, paragraph 2).

v) Review of methodological rigour
The methodology section highlighted the debates concerning the application of the quantitative research terms of validity, and reliability, and concepts of objectivity to qualitative studies. Greenhalgh (2006) and Spencer et al. (2003) identify the transparency of method reporting to be one key way of judging validity of qualitative studies, with a need to explain in detail the methods used for collecting data. The methodology section of this study endeavoured to achieve this aim, and the review of methods sections above is believed to have furthered the achievement of this transparency. Similarly it has been the aim of this work to explain in detail the approach to data analysis, and to reflect on the strategies employed in order to provide transparency of process.

A second aspect of validity, and area of greatest controversy is in relation to judgement of the truth or credibility of findings. This study has used extracts of quotes from study participants, and visual image data in order to verify claims made, and also has used field note and research diary records in an attempt to convey the experiences and understandings of the researcher (Spencer et al.

2003). This use of multiple sources of data and replication (multiple case studies) gave depth of understanding to the study and may have contributed to its' validity (Yin, 1984). The study has also endeavoured to use the existing literature in order to underpin explanations, to identify and verify patterns found in the data (Patton, 2002).

Notions of reliability (replication) are problematic in qualitative studies (Spencer et al. 2003) as the researcher is considered to be the primary instrument. As outlined in the study design section this study is located within a reality-orientated perspective, which although seeking methodological rigour, recognises that subjectivity and judgement of the researcher is inevitable. The study therefore does not seek internal reliability (other researchers would analyse the data in the same way), and recognises that the methods used (in particular observation) are not "neutral", but has sought instead to give a clear account of how the research was conducted and interpretations were made, adopting Lincoln and Guba's (1985) interpretation of reliability as "auditability, dependability, or reflexivity", and Spencer et al.'s (2003) recommendation of an "audit trail".

For these reasons the data analysis strategy did not include inter-rater reliability type approaches where individuals other than the researcher also code material, and coding is compared and agreed, or respondent validation, where data is returned to and discussed with participants. It is argued that the researcher, as the individual who has experienced the settings, has formed understandings that have framed the data gathering and analysis process, which may differ from that of other individuals who have not experienced the same settings. This decision is

supported by authors such as Morse (1997) and Silverman (2001). Morse argued that secondary analysis of data by researchers removed from a project can "violate the process of induction", as their interpretation is limited to the transcripts, resulting in superficial analysis.

During the data collection process, a form of respondent validation was used, as the researcher used the interviews as an opportunity to discuss observations with participants, and also during the observation phases there was the opportunity for informal discussion with participants regarding observations made. There was also the opportunity to discuss provisional findings from other sites, later in the data analysis (in general terms without breaching confidentiality). The use of multiple methods in this way could be viewed as a form of methodological triangulation and respondent validation, thus strengthening the findings.

The reporting of this study seeks confirmability, credibility and dependability of the findings (Patton, 2002) through transparency, multiple sources of data, reflexivity, and staying close to the data. As highlighted in the methodology section, the researcher is the instrument in qualitative data gathering, and brings conceptions and prior experiences to the process. In a "subtle realism" philosophy within which this study is embedded, validity is associated with having confidence in the knowledge (Hammersley, 1990). This study has sought to achieve this confidence by describing the data gathering, and analysis process in depth, and showing how the interpretations of the researcher have been reached.

Another assessment of quality of a research study that is the subject of much debate in qualitative research is the application of notions of generalisability. This debate was explored previously in the study design section. The study reports findings from three sites providing care to stroke patients across a typical care pathway. The sampling strategy for the study sites is explored in detail in the design section, and did contain an element of convenience sampling as the sites were required to be located within easy travelling distance of the researchers home and work, and due to ethical considerations, within the same Strategic Health Authority. The study sites selected are believed to be typical of those to be found in the Strategic Health Authority studied, and may be typical of stroke teams in other locations. By considering data describing organisational conditions, it may be possible for researchers and other services to judge whether the study findings have applicability to their location.

Part of the research question however was to investigate the effect of context on service delivery, and it is argued that context, and in particular organisational conditions have a significant impact on functioning on professionals who provide care for people who have suffered a stroke. Anderson et al. (2005) argue that organisations are highly complex social systems that need to be considered as an integrated whole, and advocate the use of case studies such as this, to capture this complexity.

The ability to generalise these findings to other stroke services may therefore be affected by local organisational conditions. The study however has highlighted the importance of the impact of organisational conditions on joint working, and

has identified specific elements of the organisation conditions, findings that potentially can be applied to other services.

The study has suggested that interprofessional network working is a different form of working to teamworking, and that teamworking may be context-bound. It has suggested that whereas interprofessional network working describes practice that is common across healthcare, the specifics of practice may vary within each individual team. The rehabilitative element of stroke care may be a significant element of working practice in this study. This finding suggests that the main applicability of this study may be to healthcare services working in the context of rehabilitative care, but that the frameworks proposed may be relevant for describing joint working practice across a broader area. This applicability of the findings will be further explored in the following conclusions and recommendations section.

6. CONCLUSIONS AND RECOMMENDATIONS

The stimulus for this work has been government-led change to working practice in healthcare, which is driving the move to increased joint working in stroke care. Examination of research evidence underpinning the link between changing working practice and better patient outcomes in stroke confirmed the need for greater understanding of the elements of joint working practice to enable potential links between changing practice and improved healthcare provision to be made. This study therefore sought to elucidate the meaning of joint working, to identify the elements of practice and to explore whether different types of joint working practice could be discerned, in order to inform the evidence base regarding the impact of working practice on patient outcomes.

The study has achieved its objective of clarifying the constituents of joint working, and has identified a framework of joint working practice in stroke that consists of twenty-six elements within six key domains. It proposes that these significant features of practice could be used to compare service delivery across different sites providing stroke care. By clarifying understanding of the elements of practice that underpin joint working, the investigation has added to the knowledge base, offering the potential for types of practice to be better evaluated and compared. It has been argued throughout this work that greater clarity is essential if there is to be better understanding of the impact of changing practice on client care.

It has also considered the relationship between terms, that as the literature review described, are currently used variously to describe joint working. This study has

argued that two different forms of joint working can be identified, and has proposed the features that can be used to mark them apart. It is argued that interprofessional network working is a less close working relationship, describing formal channels of communication and transfer of information between professionals. Teamworking in contrast is identified as being a closer relationship between professionals; where team process factors such as defined leadership, shared goals, and group support are apparent; where there is knowledge sharing; and where informal communication systems operate.

This study suggests that the evaluations of joint working currently used in stroke audit, such as frequency of meetings and record keeping may not sufficiently differentiate or accurately describe the reality of service delivery, and are unable to distinguish between the two forms of joint working, namely teamworking and interprofessional networks. The importance of informal systems of communication, for example has been highlighted, an important feature of teamworking, and a key decision-making system that has received little attention to date in regard to describing successful working practice.

The importance of organisational factors in supporting or adversely impacting on joint working has also been outlined. It has been argued that there is a need to consider working practice within a systems perspective rather than focussing solely on individual and team functioning. The study has highlighted that services require supportive organisational conditions to achieve, what is a highly complex task. It is contended that the current climate seems to focus on addressing factors within sites providing care, such as information transfer

systems, while appearing to put less emphasis on addressing organisational factors such as employment conditions and location. It is also emphasised that factors such as location of staff to each other, frequency of contact, and defined team membership are key determinants of practice, and need to be addressed if teamworking, rather than interprofessional network working is to be fostered.

Within the framework of practice that is proposed, it is important to consider the interrelationship of the elements, and drawing on Systems Theory and Chaos Theory, to recognise that working practice is a highly complex, ever-changing, interdependent social system, and that attention to individual elements within practice is unlikely to achieve the wide-scale change that is being sought. It is argued that the elements of practice identified are in a complex relationship with each other, with the perceptions and values of individuals, team interactions, and organisational conditions evolving and changing over time. This view differs significantly from a widely-held perspective in healthcare which sees unidirectional layers of influence from policy, impacting on an organisation, which is in turn fed down to a team and is carried out by individuals (Dopson & Fitzgerald, 2005).

The findings of the study highlight that in order to effect changes in working practices, it is not just service delivery that has to be the focus of policy. This study has addressed the working practice of health professionals, rather than endeavoured to address pre-registration or continuing education. It is important to note however, that the education and training of healthcare staff has also has been under scrutiny, with pre-registration professional programmes being

actively directed to develop common learning and interprofessional education as core components of curricula, in order to "enable staff to work more effectively across traditional occupational, professional and organisational boundaries" (NHS Improvement Plan 6.14). Whilst this study has not been directly concerned with examining education, it has implications for these changes to health professional training, with the finding that the organisational context has a highly significant influence on practice. Further work is needed to explore the implications of this finding as it may be that changing education is of limited value if the working environment that graduating practitioners enter is unchanged.

This suggestion similarly holds true for continuing or post-qualification training. One of the findings concerned the lack of training that staff had received in how to work together successfully. This study suggests that there is a need for greater emphasis on training staff to work together in order to achieve successful functioning. There is a need for greater clarity of performance indicators for interprofessional networks and teamworking, in order that staff are able to evaluate and review their practice, with training being offered where needs are identified. However, as argued above, there should be full consideration of the working environment that staff return to following any training. It is argued that if the environment is unsupportive of new ways of working, it is hard to imagine how changes to practice will be successfully achieved.

In further regard to training, the data also suggests that while interprofessional network working may remain constant, teamworking may differ according to the

particular context and client group. This also has implications for initial and post-qualification training of staff as changing practices in different contexts or situations suggests that it may not be possible to "learn teamworking". If working practice is context-dependent it may be that functioning may differ according to the individual team, with for example individual particular roles or behaviours being defined within an individual team context. The model showing the relationship between teamworking and interprofessional network working illustrated in Figure 5, provides the potential to distinguish elements of practice that may be common across all contexts (formal communication systems, communication of decisions, and knowledge exchange) versus those elements that are specific to an individual team. The data supports the view that as working practice changes over time, expecting fully functioning team members on graduation may be unrealistic, but graduates should possess the skills to be able to function within interprofessional networks. Ongoing monitoring and further training after qualification may be needed as an individual becomes more experienced, in order to develop their teamworking skills.

This notion of team-specific roles for individuals may continue to develop as a feature of joint working in the future if the moves towards role blurring and redefinition outlined in the background to the study continue, with traditional professional role demarcations becoming reduced. If practice is to be fully patient-centred, with skill mix defined by the needs of the care group, then working practice and role of individual members is more likely to become more team-defined, rather than profession-defined. The discussion section highlighted important considerations regarding potential impacts on professional identity,

role clarity, and individual responsibility however, that need to be considered if role blurring and redefinition is to be further pursued.

The influence of professionalism has emerged as an important factor within interprofessional networks and teamworking, and further research is needed to understand the development of professionalism and its role in practice. Further work is also needed to investigate the area of professional knowledge acquisition and knowledge sharing, which has been highlighted as being more complex than knowledge and skills transfer. This study has argued that professional knowledge and knowledge transfer or sharing is a key aspect linked to role boundaries and role blurring, and requires further investigation.

Qualitative studies such as this are helpful methods for developing greater understanding of complex phenomenon, such as working practice and organisational functioning. The qualitative methods used in this work have been able to generate large volumes of data in order to build explanations, a cornerstone of arguments for employing a qualitative methodology. They have also been able to gain an understanding of practice in the field, and have been able to shed further light on complex whole-system elements, and interrelationships between elements, which can be seen as a further strength of this methodology.

The data generation methods of fieldwork observation and interviews have been successful in gaining insight into staff and patient viewpoints and have provided the opportunity to make cross-comparisons between data types. The visual

image data has also proved to be a significant supplement to strengthen the findings, and the use of team diagram drawings is recommended to other researchers as a helpful strategy in gaining an understanding of team process and relationships.

Whilst considering that the findings of this study are robust, it is recognised that the researcher as the primary tool in data gathering and analysis cannot be seen as viewing the data through a completely "neutral observer" lens, and that individual interpretations of the data are inevitable. This study has investigated a small number of sites, providing care to a single patient care group, in one region of the UK. The possibility that working practice in stroke may be different to care for other patient groups has already been raised, and this needs further exploration. By presenting the data gathering and interpretation process in detail it is hoped that this will aid replicability of this work by other researchers. Other similar studies investigating the complex phenomena of healthcare working practice are needed to discern if these findings can be generalised to other services.

This study chose to refer to healthcare practitioners working together as joint working, and sought an understanding of the terms interprofessional and teamworking, terms that are used in UK government policy documents for stroke care, and are the most frequently used terms in the literature when describing joint working. It is important to note that whilst this study has been concerned with these terms, there are a number of other related terms that are also used in the literature to describe joint working practice, including multidisciplinary,

interdisciplinary and transdisciplinary. These terms, which are most often used in the North American literature, rather than by European authors, suggest a concern with transfer of knowledge and skills between specific disciplines (Payne, 2000). This study suggests that transfer of knowledge and skills is a key element of working amongst professionals, but is only one element of joint working, and therefore these terms have limited usefulness by not encompassing all elements of practice that are required in successful joint working. It is possible however, that these terms, if forming a continuum of knowledge and skills acquisition across discipline boundaries, could specifically describe this one aspect of joint working practice, rather than describing joint working as a whole. They could therefore be used to indicate the increasing blurring between professional knowledge and skill roles, one aspect indicating a move from interprofessional network operation to fully functioning teamworking. This would be interesting to explore with further research.

Implications for further research

It is recognised that this work has reported findings from a particular client group, in a small number of study sites, and in common with most qualitative studies makes no claim to generalisability. Further work is needed to assess whether the framework of practice identified is transferable to other client groups and other contexts, and whether interprofessional network functioning is a general working practice, but teamworking is context-specific. The finding that a rehabilitative model of healthcare was significant for the study sites, suggests that other areas, with different client groups, adopting a more medical viewpoint may operate a different type of working practice. Further research is therefore

needed to determine if interprofessional network and teamworking are concepts that are applicable across all areas of care, or are more appropriate for particular client groups.

Linked to client group, is the position of the service user in professional working practice. This investigation suggests that the concept of "patient-centred care" is a well-used, but currently unclear concept, and that the role of the service user in teamworking requires further clarification. The literature review described the change in healthcare relationships between staff and patients, with services being "patient-led", and increasing recognition of the patient as being an expert in their own health resulting in changing power differentials. Payne (2000) sees a contradiction between being team focussed, and joint working including service users, and this investigation supports the need for further consideration of this seeming dichotomy. This study has highlighted that a particular challenge for healthcare teams is to counterbalance the importance of team process factors, with the requirement to be responsive to service user needs and service user involvement.

This examination of care delivery has not fully explored the service user perspective, and this could be seen as a weakness in design, with only a small number of service user participants taking part in the patient interviews, forming a subsidiary element in the data analysis and interpretation. The study had as its focus the exploration in depth of the professional perspectives on care delivery, examining the relationships between staff, and between staff and the context that they operate within. The focussing of data gathering around the selected patients

at each site provided depth to the process, and acted as a sampling strategy, however was unable to permit the exploration of perceptions of sufficient numbers of patient participants. The service user perceptions have however proved valuable in strengthening the data, and in offering a further view or perspective on observed and reported findings. A study of patients and their family would be an important area for future studies.

The literature review highlighted that the link between joint working and benefits for the service user is currently under-researched. Although not exploring the issues in sufficient depth, this work has identified areas which may be investigated in future research. The data suggests that the potential benefits may be: a more speedily provided service delivery; a broader understanding of an individual user and their needs by the professionals involved with them; shared clinical problem-solving amongst professionals; and shared decision-making. Further exploration of these potential benefits is needed in future studies.

The data suggests that staff perceive benefits of joint working in terms of greater sharing of knowledge and information, and a reduction in individual responsibility. Further work is needed to investigate whether these benefits outweigh any potential losses such as reduction in time available for care, and defined responsibility.

The background to the study section highlighted the government-led policy documents and inquiries into failures in care in the UK that have driven the call for changes to working practice. It also highlighted that increased joint working

is not only a UK policy initiative, but is an international call. It is interesting to note that whilst in the UK and most of Europe it is the quest for improved care that is driving changes in working practice, on other continents there are different motivators. In North America, it is patient safety and the potential for joint working to reduce medical error that seems to be the motivating factor. Alternatively, in Australia the need to provide healthcare to rural and remote populations is underpinning role blurring and joint working.

These different understandings of the purpose for changing practice highlight the complexity and lack of clarity in the area, and offer the possibility that even if links between outcome and changed working practice cannot be made, that there may be other valid reasons for introducing changed practice in the UK, such as improved patient safety. It remains important however, that arguments for substantial change in healthcare are based on sound research evidence, and that any changes introduced can be evaluated.

The work has highlighted that there is a need for researchers engaged in future investigations to provide detailed descriptions of practice under scrutiny, with clearer use of terminology. Researchers should pay attention to the dimensions and elements of joint working identified here in any evaluations of practice. Studies attempting to elucidate care-outcome links need to distinguish the type of joint working being examined, identifying whether it is teamworking or interprofessional network working that is being investigated, when reporting their findings.

This call for greater clarity in understanding the elements of joint working, and in use of terminology is not just a pedantic distinction. The literature review highlighted the current difficulties in establishing an evidence base for changes to working practice, with lack of demonstration of a link between practice and either improved care outcomes or improved service delivery. If the impact of significant reform is to be evaluated in future studies, it is essential that the precise nature of the work under scrutiny is known.

As this investigation has argued, interprofessional and teamworking are well-used terms to describe joint working practice. There is a need to see beyond the rhetoric however, to develop our understanding of what these terms describing practice actually mean if changes to healthcare systems are to be evaluated and compared. It is hoped that this study has gone some way towards a better understanding of joint working practice in one area of healthcare delivery, describing the meaning of interprofessional networks and teamworking in stroke care.

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APPENDIX 1. STAFF INTERVIEW SCHEDULE

Appendix 1. Staff interview schedule

1. Organisational conditions
What is the management structure for your job? Who is your line manager? Who would be involved in decisions regarding your working responsibilities? Who appoints people to your post?

2. Common purpose/goal
If you had to summarise in one or two sentences, would you say is your main goal for (name of patients selected). What is the main goal for (another selected patient) and finally for (third patient).

3. Handling conflict, problem-solving
Is there ever conflict within the team? What sort of conflicts might there be? What would happen, how would it be resolved?

4. Group process and team roles
Would you say you had a particular role within the team as an individual? Have you ever had any training in team working either before you qualified, or since you have been working?

5. Professional roles and identities
How long have you been qualified? Who do you mostly go to if you are uncertain or want to find something out?
How does the team decide who is going to do what for a patient?
When you are working, do you think of yourself more as a (profession) or a member of a team?

6. Individual (self) beliefs/characteristics/identity
Have you worked in teams before? What have been your experiences?
What do you think are the most important attributes someone needs to have to work in this team?

7. Client/user involvement
Who makes most of the decisions about client care? Who decides when clients can go home/finish treatment.

8. Communication systems
How much of your average day would you say is spent working as a (profession) and how much working as a team member?

APPENDIX 2. OBSERVATION SCHEDULE

9. Leadership/authority/power
How leadership decided and how operates. Who has authority and power, how determined.

10. Common purpose/goal
Client focussed, individual professional focussed, or team focussed.

11. Handling conflict, problem-solving
Mechanisms for this, participating in change, creative working methods, openness and honesty. Decision-making process, closure decisions, priorities

12. Group process and team roles
Understanding and commitment to group process. Understanding and valuing of member role and function. Group norms, expectations, boundary to group, individual role and identity within group.

13. Professional roles and identities
Level of competence/experience. Knowledge of boundaries of own and others. How these decided and how changed. Professional identity versus team identity. Professional standards maintenance, supervision systems.

14. Individual (self) beliefs/characteristics/identity
Attitude to working together, previous experiences. Ability to manage self and others, personal and professional growth. Trust, respect, honesty, openness.

15. Organisational conditions
Accountability, governance, support for team, training, structure, staffing, appointment, management

16. Client/user involvement
Role and balancing of client needs, team needs, professional needs.

17. Communication systems

APPENDIX 3. PATIENT INTERVIEW SCHEDULE

Appendix 3. Patient interview schedule

The following are the key areas for discussion, with examples of questions that will be asked. As the method is a semi-structured interview the researcher will be flexible in terms of order of questions and specific questions asked.

18. Team membership

Who would you say makes up the team of people looking after you?

Is there anyone else who is involved in your care?

For each one of the people you have mentioned, can you tell me a little about what you think their job is in looking after you.

19. Team working

Who makes decisions about your care?

What do you think about the way the staff looking after you work together?

APPENDIX 4. LIST OF DOCUMENTS FORMING THE DATA

Appendix 4. List of documents forming the data

Number of Documents: 79

1	diary of data analysis
2	field notes 1
3	field notes 2
4	field notes 3
5	field notes 4
6	field notes a
7	field notes b
8	field notes c
9	field notes d
10	field notes e
11	field notes f
12	field notes g
13	field notes h
14	field notes i
15	field notes j
16	field notes k
17	field notes l
18	field notes m
19	field notes n
20	field notes o
21	field notes p
22	field notes q
23	field notes r
24	field notes s
25	field notes t
26	field notes u
27	field notes v
28	Field notes w
29	field notes x
30	field notes y
31	field notes z
32	individual Interview 1
33	individual interview 10
34	individual interview 11
35	individual interview 12
36	individual interview 13
37	individual interview 14
38	individual interview 15
39	individual interview 16
40	individual interview 17
41	individual interview 18
42	individual interview 19
43	individual interview 2

|	
44	individual Interview 20
45	individual interview 21
46	individual interview 22
47	individual interview 23
48	individual interview 24
49	individual interview 25
50	individual interview 26
51	individual interview 27
52	individual interview 28
53	individual interview 29
54	individual interview 3
55	individual interview 30
56	individual interview 31
57	individual interview 32
58	individual interview 33
59	individual interview 34
60	individual interview 35
61	individual interview 36
62	individual interview 37
63	individual interview 4
64	individual interview 5
65	individual interview 6
66	individual interview 7
67	individual interview 8
68	individual interview 9
69	patient interview a
70	patient interview b
71	patient interview c
72	patient interview d & e
73	patient interview f
74	patient interview g
75	patient interview h
76	patient interview j
77	patient interview k
78	patient interview l
79	thoughts and ideas

APPENDIX 5. NODE FREQUENCY COUNT

Appendix 5. Node frequency count

Node	Number of passages coded	Number of documents coded
Organisational conditions	235	58
Client/pt experience	194	39
Role and identity/know boundaries	143	43
Knowledge and skills	134	39
Goal/purpose	129	39
Nurse role	110	37
Communication	109	32
Benefits to staff	105	33
Status + power	96	34
Ideas of what interprofessional working is	90	35
What ideal	84	28
Patient outcome	82	29
Medic role	80	31
Management	80	25
Informal communication	75	31
Assistant role	75	27
Physiotherapy role	67	22
Who decides discharge	64	29
Location	61	26
Contact frequency	56	26
Occupational therapy role	56	21
Time	54	27
Who decides care	52	23
Medical versus rehab model	52	21
Team within a team	51	28
Team versus profession	51	25
How long qualified	49	21
Written communication	49	20
Conflict	45	19
Training	40	23
Personality	39	21
Confidence	39	20
Role blurring	39	17
Leadership	35	18
Decision making	34	18
SLT role	31	17
Previous experience	30	17
Formal communication	30	13
Group norms	24	16
Professional perspective	24	11
Respect & trust	23	14
Patient role	23	12

|		
Whole person	21	13
Dietician role	20	8
Psychologist role	18	7
Group support	16	15
Other professions	6	2

APPENDIX 6. VISUAL IMAGE DATA

Appendix 6. Visual image data
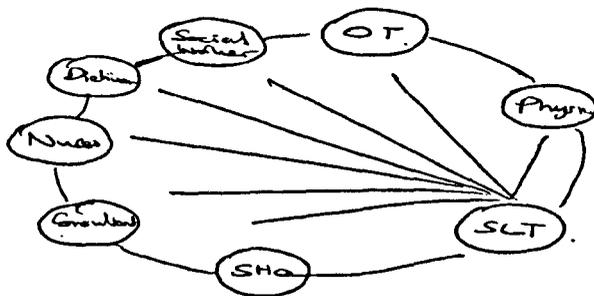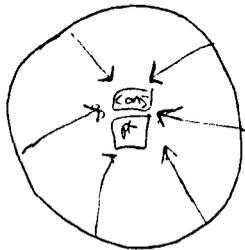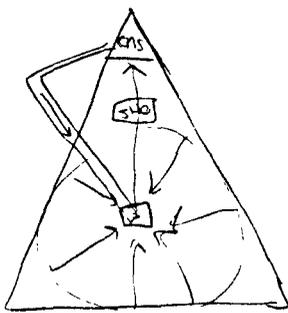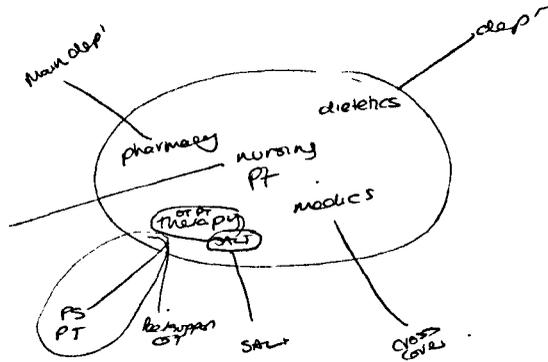
TARDIS
REFLECTIVE FLUID LIKE MIRROR
Shiny like!
Internal!

PATIENT.

BODY
COMMUNITY
SERVICES

FAMILY
PATIENT
CARERS

OUT PATIENTS.

SOCIAL SERVICES.

nurses   Physio OT SALT dietician

336

NT

Nursing

Nursing + therapy

Nursing

LEADER

MEDIC

RALS

PT

PT & FAMILY

OT

SET

PSYCH PSY

DIET

COUN

NURSE

Modic ___

Psycho

or

Phiso

As

nurs

Communical
Active / Listening

X (Teamleader)

Outside
specialists
by X.

Specialists. — all disciplies.

Developing specialists / rotational
staff

admin.

As

Patient

PT   NS   OT

R.A

SLT

Medics
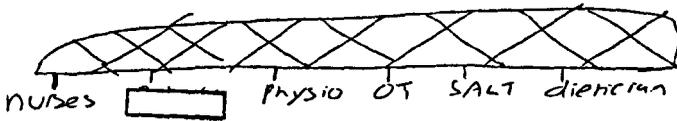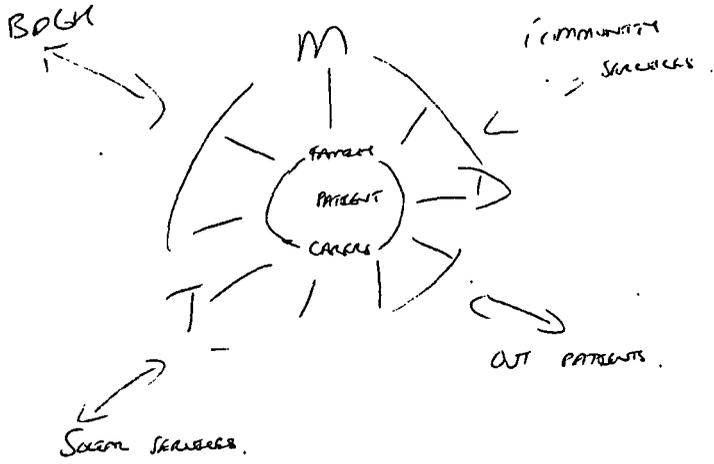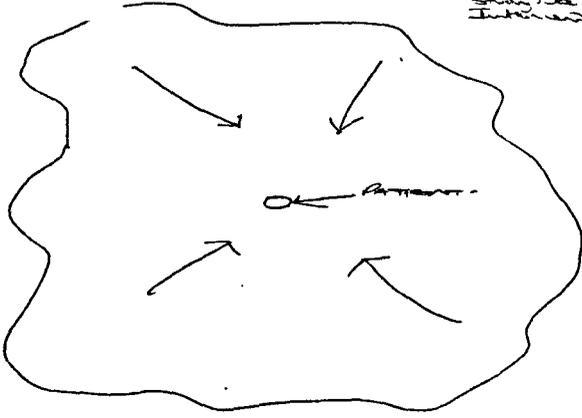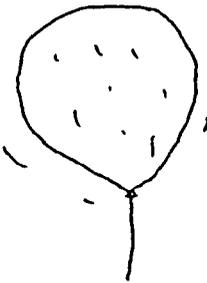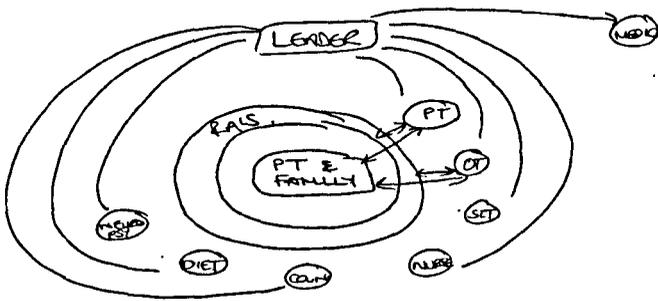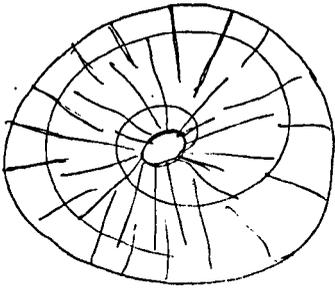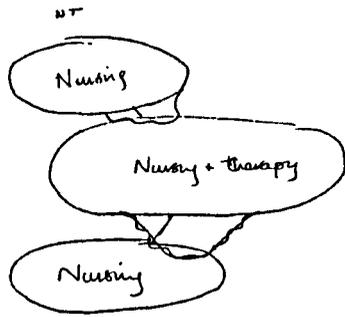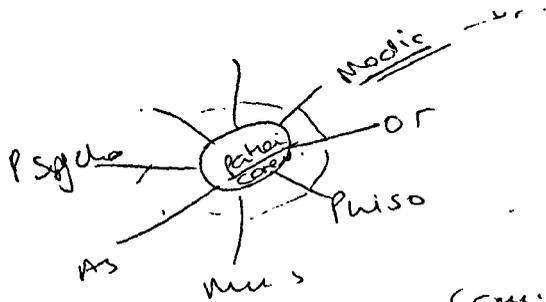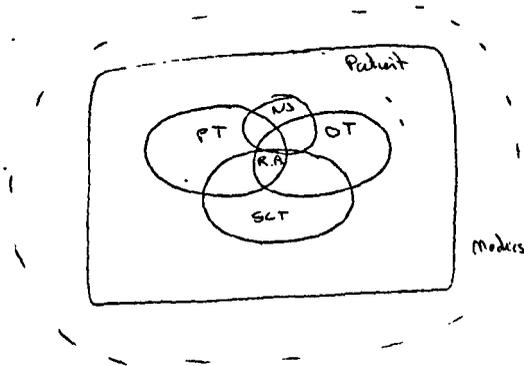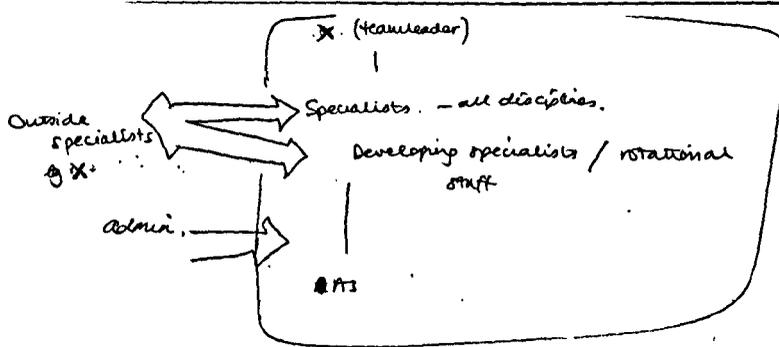
APPENDIX 7. SAMPLE INTERVIEW TRANSCRIPT AND CODING REPORT

Appendix 7. Sample interview transcript and coding report

1: Interviewer

2: the first thing to do with team working is the organisation or the background that people work in...is known to influence how they work..so I am checking out with people what their management structures are like...who they report to....who does their supervision all that kind of thing....so.....within the team there isn't a kind of....well who would you report to...if you had a problem....

3: Participant

4: depends who's here....used to be x the # until.....she were the # so she were our direct line manager.....before going.....

5: Interviewer

6: so was she the team leader as well then....

7: Participant

8: no there was no team leader......until x taken over...some time last year before y left...and x became team leader cos it were inferred that there were a problem.....not a problem...but a need for a team leader.....so....yeah...they did it as a secondment......yeah our line management...now...in the first hand it would be x I would go to.....um...but obviously cos she's really really busy and if there's nobody around.....the senior staff lieu time and things like that...senior staff...or if it were a physio based problem straight to physio ....or OT.....senior staff....

9: Interviewer

10: and you've got kind of a nominated person.....

11: Participant

12: yeah......z...is mine...cos I've got a physio interest anyway....that's how it was arranged originally.....yeah....z has got an OT interest so obviously y took z.....

13: Interviewer

14: I just guessed it was kind of random.....

15: Participant

16: z has got a psychology and counselling so she goes to x...that is how it was set out in the beginning....

17: Interviewer

18: and how long have you worked within the team

19: Participant

20: # years...

21: Interviewer

22: so was that when it pretty well started...

23: Participant

24: # years.....team...were set up...when I started up there was just x and I as assistants...there was....x...got her job in January and there was identified for funding and I got the job in....the june....(section deleted for confidentiality)

25: Interviewer

26: so they all came in together then did then...

27: Participant

28: # came in making #

29: Interviewer

30: so does it all work...all the structures..the management ...having the team leader

31: Participant

32: yeah....I mean a few years back we did a team presentation and all the team managers came to get all the different line managers came together...it was to get extra funding for therapists....and cos the bottleneck in the patients...so yeah...quite interesting....cos everybody has got direct managers to speak to...before it all comes back as a team...and .....yeah....

33: Interviewer

34: and they all came..

35: Participant

36: yeah and I think it was for everybody to hear at the same time what was happening....so that everybody could go back together...cos it were alright...coming from like speech therapy manager....back to speech therapy but nothing were getting translated between...all the managers ....and everybody is all on different trusts....so...

37: Interviewer

38: yeah....I know it's different employers..I thought # were bad as different ones

39: Participant

40: yeah there's #, there's #, there's #,.......

41: Interviewer

42: so you were employed directly to the stroke team....

43: Participant

44: yeah contracted for stroke team but I can be if there's emergencies.....can go on to the wards if...my contract states...but ...that would be interesting...

45: Interviewer

46: yeah it's amazing how everyone has got these different structures about management....and professional groups...cos a lot of the therapies have got kind of departments on site here as well....some of them part time some full time...rotations...

47: Participant

48: yeah for example on Friday last week I had to go home cos I got a phone call saying.......x was on annual leave...there were no senior staff in the office...to ask...x who is the team...head of the team she was on annual leave...the nurse who I have got a contact for in case of any nursing issues....on the ward...she was off the ward...so I went home...nobody knowing except for the assistants and y...but she isn't senior staff.....so I went home..phoned...y...so nobody knew from management...but nobody knew.....it's just situations isn't it.....it's like because everyone books annual leave with different management...physio book annual leave with their managers....OT do and speech.....

49: Interviewer

50: so there could be a time when there is nobody in there then cos everybody has booked their annual leave differently...

51: Participant

52: well assistants....there's only 3 allowed off at one time...and x signs all their..we put in diary....the therapies they all book with their own management...so....

53: Interviewer
54: so interesting the background stuff.....any experience of working in teams before...you came here
55: Participant
56: I worked in #...I was a # assistant...mainly and then I got assistant # post
57: Interviewer
58: so very different to this or similarities
59: Participant
60: uh........I think quite similar really...the only difference I've got is the lone working..when you've always worked as part of a two or three man team...cos there was only one or two staff and an #...or two staff and an # quite a small team but quite connected and having to work together.....and things like that...which we do here...but then you've got the lone working as well as....
61: Interviewer
62: who are the people you tend to work with most ....are they other assistants or...
63: Participant
64: everybody...um...I do a lot of work with x and y...very few nursing patients I've had...speech and language they are just picking up again...cos they've got z who is...# assistant...so it's normally patients we're already involved with....that we pick up for # or patients.....if she's got no gaps...we take on...
65: Interviewer
66: I wondered how that worked...cos it is slightly odd in a way...that there's a # assistant and then other assistants as well...
67: Participant
68: well she's BTech....um...qualified and things like that...so she's higher level than we would do a # at....so...yeah she tends to do...
69: Interviewer
70: yeah cos I was trying to work that out....who would see who....but it often comes down to if you are already working with someone...
71: Participant
72: yeah if I pick somebody up from...physio...and it was highlighted that they needed a programme...then x would be able to pass it on to me...she wouldn't pass it on to somebody else...so we could end up doing three therapies all in one.....not in one visit..we try to split them...but depending on patient whether they can cope with three....mix them up....
73: Interviewer
74: I was going to say how do you cope when you get programmes from all these different.....people
75: Participant
76: hopefully physio and OT can combine....and then speech and language you've got tactics anyway you can involve....in that...and then do a separate programme aswell as.....it depends on how much the patient can cope with.....
77: Interviewer
78: but it's mostly do-able is it...you're not getting bombarded with stuff to do ....
79: Participant

80: no not at all...cos everything is quite gradual anyway...with the waiting lists some have been going in quicker than others so....you're all ready well aware of the patient......

81: **Interviewer**

82: so do they wait for different times then....physio waits more

83: **Participant**

84: no...I think OT is waiting a bit longer at the minute than physio....just how it happens...how it goes on that week...waiting list....yeah....so....

85: **Interviewer**

86: yeah...but you wouldn't start doing any OT work until the OT has seen them......

87: **Participant**

88: depends if they have come on a # programme..cos it could be set....a physio and an OT programme ...so we could be doing that....until...say x went out first from physio...and then y went out four weeks later...so you could still be doing an OT programme in the meantime...

89: **Interviewer**

90: oh right...cos I was trying to work out if you were doing a physio programme and the OT hasn't seen them..could you do any OT

91: **Participant**

92: yeah you carry it through..but then they come out and review that programme......to see whether it needs moving forward but in the meantime....you can go back on to the ward....cos OT's don't discharge for six weeks....so they are actually under their care...physios discharge straight away....from discharge...from hospital...but OT are six weeks.....like social workers...have so long after.......so...

93: **Interviewer**

94: it's really odd the way this...the historical traditions...

95: **Participant**

96: yeah...and they take responsibility then you see with the programmes and that.......

97: **Interviewer**

98: gosh...interesting...is there anything about team working that here in this team you think is either particularly....good or....could be a lot better than it is.....

99: **Participant**

100: there is no hierarchy in this team.......there's not between the therapists and the assistants.....there's not I'm qualified and you're not..cos I think at some places....you get that...and definitely where I came from before there was management.....and there was staff.....um but there's not apparent at all...everybody is a team and I think that's part of it....

101: **Interviewer**

102: yeah.....so it's quite an important feature.....are there particular skills of teamworking that you think you need to work in this team....if somebody was coming in....

103: **Participant**

104: I think you need to be team players....everybody needs to be aware that they are not a lone worker and.....alone....and work alone...cos you've got to work as part of a team and you've got to feedback and you've got to be

there....for each other and that ....and I think if people can't do that.....or.....are quite used to be alone.....

105: **Interviewer**

106: have you ever had anybody come in the team....that's not sort of done well or not liked it or hasn't got on......and had to sort of leave...

107: **Participant**

108: no...I think some people come into the team and struggle to get that....concept that it is a team...and people work....closely with each other instead of being a lone person and you're out there and that's it...cos it doesn't exist that.......

109: **Interviewer**

110: so certainly that team player bit.....is it possible....to kind of put your finger on what it is about being a team player...are there certain ways of being that make you a team player

111: **Participant**

112: I think cos there's no hierarchy and things like that...and whatever you input is considered....and....you know what I mean...they never say oh you're not qualified so you don't know that....or....it...everything is took on board...it is an MDT...and if we didn't all work closely the team wouldn't work.....I don't think....

113: **Interviewer**

114: do you see benefits for yourself of working in a team ...do you think it's a better way to work....

115: **Participant**

116: yes.....I don't see how you can work as one person and the team be here...I don't know....because there are so many people involved with a person's care it needs to be a three way thing or a four way thing or.....including patients....

117: **Interviewer**

118: is there anything about stroke that makes that different....or...unique or is it the same for anything

119: **Participant**

120: I wouldn't know cos I've not worked any where else....

121: **Interviewer**

122: that's one of the things I am quite interested in.....whether stroke has a particular way of working with it....

123: **Participant**

124: I don't............I don't know cos I don't think you'd get the closeness that there is......it seems to work the team....so...the people who are employed....whether it's the knowledge of the people who's employing.....and knowledge of.....well all the assistants were interviewed...I was definitely interviewed by x who was on the ward...the stroke co-ordinator and z......so it was people out of the team......x was sat on the interviews.....so it's people involved with the interviews.........and can pick out personalities that can work.....

125: **Interviewer**

126: so maybe that's why it's worked so well...they pick out people they are looking for....cos you'd have thought that...almost kind of statistically the likelihood is that somebody one day might not fit......

127: **Participant**

128: but then if the majority of the team work that way then they would be in a minority wouldn't they.....and I think they'd struggle if they wanted to change that.....I don't suppose it's gonna happen for ever that we're not gonna find the one.....

129: **Interviewer**

130: it does have a nice kind of atmosphere about it....

131: **Participant**

132: yeah...I don't think there's anything....there's nothing massive that I can ever think.....you're always gonna get ruptions...you're always gonna get disagreements...but I think all of them are aired.......and dealt with....I think things have been dealt with....and then....get on with it.....

133: **Interviewer**

134: cos in a lot of teams you get kind of cliques you know team.....little teams....certainly my perception hasn't been that that has been going on here...that you don't get kind of people in a corner huddled and not talking to anyone else...

135: **Participant**

136: no definitely not...all of us....I mean there are a lot of us who worked previously cos we were in different offices before and the team was a lot smaller.....so before we got the new therapists before we got the new assistants.....so a lot of us know each other personally ......and things like that outside work...which are friendships that have come through work.......um.....and x and I and y and that go #....but that is something that we have always done...but I don't think as of little cliques I don't think there is.....

137: **Interviewer**

138: cos you can get that in teams.....I wonder if it is something to do with having the big office...you can't go and natter about somebody behind their back cos there is nowhere to do it

139: **Participant**

140: yeah.....I don't think anybody does rant......I ....no...I think if anybody says owt it is mainly said to them.....I don't ...and there is always time for a one to one anyway if you are in the car with them.....if you're I mean when the new assistants started it was very much a # and a #........when they first started cos they had had a #week induction programme....and they were put together for # weeks and they were coming in to a post that we were already involved in....so in the beginning it was quite like that.....and we'd not been introduced to them and they'd not been introduced properly to us....and it was just something um.......I personally.....cos we took everybody out on shadowing and I......asked...if there were any problems anything to do with me....and it was just an atmosphere that had been created and which has now totally gone......um.....yeah....I think it was just # of us had been in post a while and # were just invaded into us......well where do we stand from here......and it's not a problem now......and I think if they had introduced everybody one by one.....

141: **Interviewer**

142: well # out of # it's a big chunk

143: **Participant**

144: well if everybody had come in like x on her own....then I don't think ....I can't imagine it can be nice for x.......

145: **Interviewer**

146: maybe you have to integrate more

147: **Participant**

148: yeah.....you've got no choice...yeah cos # people they used to come in and go down to the canteen for lunch....cos in their training they went to the canteen......we all sit here for lunch.....but it was just something they had got in to the habit of....but that's all gone now......but....I do think that was the amount of people that was interviewed and started at the same time.....cos they had built up their friendships before being integrated into the team.....

149: **Interviewer**

150: do you think there's still clarity within the team about who does what....you know an OT role and a physio role...or is there any kind of blurring going on

151: **Participant**

152: no I don't think there is

153: **Interviewer**

154: so pretty clear is it

155: **Participant**

156: yeah......I think everybody has got well defined posts.....and ...yeah I think we're quite well informed of what each therapist does and who to ask......and...if we're not sure it comes over at team meeting and then it's decided within the team so.....so.....

157: **Interviewer**

158: one last thing I have been asking people to do....is....to ask people if they have got a picture in their mind of what the team looks like and to draw it...so if you had to think about what it looked like have you got a picture.....

159: **Participant**

160: a balloon that's what I picture....everybody in a balloon

161: **Interviewer**

162: what in the basket bit....

163: **Participant**

164: no.....a balloon balloon....just in the balloon.....just a balloon with a string on.....that's what I imagine....just everybody in there...compact and everybody in there.....

165: **Interviewer**

166: so who would actually be the team....so the assistants....and what physio OT speech therapy

167: **Participant**

168: secretary.....cos ......with us moving the secretaries are stopping here...cos our secretary even though she was for # and # she was based here...full time so she knew....the team were a lot smaller but she were there five days a week.....so she knew where everybody was...is so and so coming....no where is she.....and so the secretary were like the link between everybody....

169: **Interviewer**

170: so who else have we got...the dietician....

171: **Participant**

172: dietician yeah.....

173: **Interviewer**

174: psychologist....social work...

175: **Participant**

176: and I'd have all the managers out here......just on this out ....

177: **Interviewer**

178: and the team leader

179: **Participant**

180: she'd be in the middle........cos I think that's a huge part of the team.....the team leader post is gonna be advertised now...but I think that's when it was highlighted like the team leader post

181: **Interviewer**

182: so where would the patient client be.....in the circle as well

183: **Participant**

184: yeah....I think like you've met x ......he has got physio OT two three four assistants who's known to x....um...just to cover annual leave like that and he's just a huge factor in that balloon in part of the team.......so.......

185: **Interviewer**

186: well that's a nice image cos a balloon is going forward maybe....

187: **Participant**

188: definitely not on the ground cos...we're not.....I think everything's just moving...so......

189: **Interviewer**

190: that's a nice image.....thank you for that.....I must let you get off....

DOCUMENT CODING REPORT

Node 1 Context
Passage 1 of 1 Section 0, Para 60, 163 chars.

60: quite a small team but quite connected and having to work together.....and things like that...which we do here...but then you've got the lone working as well as....

Node 2 Responsibility
Passage 1 of 1 Section 0, Para 96, 67 chars.

96: they take responsibility then you see with the programmes and that.

Node 3 Stroke client group
Passage 1 of 2 Section 0, Para 80, 39 chars.

80: cos everything is quite gradual anyway.

Passage 2 of 2 Section 0, Para 116, 145 chars.

116: because there are so many people involved with a person's care it needs to be a three way thing or a four way thing or.....including patients....

Node 4 Organisation/management
Passage 1 of 4 Section 0, Para 4, 159 chars.

4: depends who's here....used to be x the # until.....she were the # so she were our direct line manager.....before going.....

Passage 2 of 4 Section 0, Para 8, 282 chars.

8: in the first hand it would be x I would go to.....um...but obviously cos she's really really busy and if there's nobody around.....the senior staff lieu time and things like that...senior staff...or if it were a physio based problem straight to physio ....or OT.....senior staff....

Passage 3 of 4 Section 0, Para 32, 86 chars.

32: cos everybody has got direct managers to speak to...before it all comes back as a team

Passage 4 of 4 Section 0, Para 36, 198 chars.

36: cos it were alright...coming from like speech therapy manager....back to speech therapy but nothing were getting translated between...all the managers ....and everybody is all on different trusts...

Node 5 Organisation/location
Passage 1 of 2 Section 0, Para 148, 26 chars.

148: we all sit here for lunch.

Passage 2 of 2 Section 0, Para 168, 302 chars.

168: cos our secretary even though she was for # and # she was based here...full time so she knew....the team were a lot smaller but she were there five days a week.....so she knew where everybody was...is so and so coming....no where is she.....and so the secretary were like the link between everybody....

Node 6 Organisation/organisational conditions
Passage 1 of 8 Section 0, Para 48, 143 chars.

48: it's like because everyone books annual leave with different management...physio book annual leave with their managers....OT do and speech.....

Passage 2 of 8 Section 0, Para 52, 158 chars.

52: well assistants....there's only 3 allowed off at one time...and x signs all their..we put in diary....the therapies they all book with their own management...

Passage 3 of 8 Section 0, Para 80, 120 chars.

80: with the waiting lists some have been going in quicker than others so....you're all ready well aware of the patient.....

Passage 4 of 8 Section 0, Para 84, 135 chars.

84: I think OT is waiting a bit longer at the minute than physio....just how it happens...how it goes on that week...waiting list....yeah..

Passage 5 of 8 Section 0, Para 92, 223 chars.

92: OTs don't discharge for six weeks....so they are actually under their care...physios discharge straight away....from discharge...from hospital...but OT are six weeks.....like social workers...have so long after.......so...

Passage 6 of 8 Section 0, Para 136, 124 chars.

136: .I mean there are a lot of us who worked previously cos we were in different offices before and the team was a lot smaller..

Passage 7 of 8 Section 0, Para 140, 220 chars.

140: I think it was just # of us had been in post a while and # were just invaded into us......well where do we stand from here......and it's not a problem now......and I think if they had introduced everybody one by one.....

Passage 8 of 8 Section 0, Para 148, 178 chars.

148: .I do think that was the amount of people that was interviewed and started at the same time.....cos they had built up their friendships before being integrated into the team.....

Node 7 Conflict
Passage 1 of 2 Section 0, Para 132, 203 chars.

132: you're always gonna get ruptions...you're always gonna get disagreements...but I think all of them are aired.......and dealt with....I think things have been dealt with....and then....get on with it.....
Passage 2 of 2 Section 0, Para 140, 105 chars.

140: .I don't think anybody does rant......I ....no...I think if anybody says owt it is mainly said to them...

Node 8 Team process/contact frequency
Passage 1 of 1 Section 0, Para 64, 141 chars.

64: everybody...um...I do a lot of work with x and y...very few nursing patients I've had...# they are just picking up again...

Node 9 Team process/group support
Passage 1 of 2 Section 0, Para 104, 109 chars.

104: you've got to work as part of a team and you've got to feedback and you've got to be there....for each other

Passage 2 of 2 Section 0, Para 124, 102 chars.

124: .I don't know cos I don't think you'd get the closeness that there is......it seems to work the team..

Node 10 Team process/leadership
Passage 1 of 2 Section 0, Para 8, 214 chars.

8: no there was no team leader......until x taken over...some time last year before y left...and x became team leader cos it were inferred that there were a problem.....not a problem...but a need for a team leader....

Passage 2 of 2 Section 0, Para 180, 75 chars.

180: she'd be in the middle........cos I think that's a huge part of the team...

Node 11 Professionalism /status+power
Passage 1 of 4 Section 0, Para 64, 55 chars.

64: they've got z who is...# assistant..

Passage 2 of 4 Section 0, Para 68, 128 chars.

68: well she's BTech....um...qualified and things like that...so she's higher level than we would do a # programme at..

Passage 3 of 4 Section 0, Para 100, 311 chars.

100: there is no hierarchy in this team.......there's not between the therapists and the assistants.....there's not I'm qualified and you're not..cos I think at some places....you get that...and definitely where I came from before there was management.....and there was staff.....um but there's not apparent at all..

Passage 4 of 4 Section 0, Para 112, 95 chars.

112: I think cos there's no hierarchy and things like that...and whatever you input is considered...

Node 12 Team process/norms
Passage 1 of 2 Section 0, Para 128, 236 chars.

128: if the majority of the team work that way then they would be in a minority wouldn't they.....and I think they'd struggle if they wanted to change that.....I don't suppose it's gonna happen for ever that we're not gonna find the one.....

Passage 2 of 2 Section 0, Para 148, 247 chars.

148: yeah cos # people they used to come in and go down to the canteen for lunch....cos in their training they went to the canteen......we all sit here for lunch.....but it was just something they had got in to the habit of....but that's all gone now..

Node 13 Team process/team within a team
Passage 1 of 1 Section 0, Para 136, 297 chars.

136: so a lot of us know each other personally ......and things like that outside work...which are friendships that have come through work.......um.....and x and I and y and that go #....but that is something that we have always done...but I don't think as of little cliques I don't think there is.....

Node 14 Professionalism /knowledge and skills
Passage 1 of 1 Section 0, Para 156, 78 chars.

156: I think we're quite well informed of what each therapist does and who to ask.

Node 15 Professionalism /role and identity/know boundaries
Passage 1 of 3 Section 0, Para 72, 173 chars.

72: so we could end up doing three therapies all in one.....not in one visit..we try to split them...but depending on patient whether they can cope with three....mix them up....
Passage 2 of 3 Section 0, Para 88, 218 chars.

88: a physio and an OT programme #...so we could be doing that....until...say x went out first from physio...and then y went out four weeks later...so you could still be doing an OT programme in the meantime...

351

Passage 3 of 3 Section 0, Para 156, 249 chars.

156: I think everybody has got well defined posts.....and ...yeah I think we're quite well informed of what each therapist does and who to ask......and...if we're not sure it comes over at team meeting and then it's decided within the team so.....so.....

Node 16 Professionalism /role and identity/slt role
Passage 1 of 1 Section 0, Para 76, 183 chars.

76: and then speech and language you've got tactics anyway you can involve....in that...and then do a separate programme as well as....it depends on how much the patient can cope with.....

Node 17 Professionalism /role and identity/role blurring
Passage 1 of 1 Section 0, Para 76, 120 chars.

76: hopefully physio and OT can combine....and then speech and language you've got tactics anyway you can involve....in that

Node 18 Individual /previous experience
Passage 1 of 1 Section 0, Para 60, 144 chars.

60: .I think quite similar really...the only difference I've got is the lone working..when you've always worked as part of a two or three man team..

Node 19 Individual /what ideal
Passage 1 of 1 Section 0, Para 104, 131 chars.

104: I think you need to be team players....everybody needs to be aware that they are not a lone worker and.....alone....and work alone.

Node 20 Individual/ personality
Passage 1 of 2 Section 0, Para 104, 159 chars.

104: you've got to feedback and you've got to be there....for each other and that ....and I think if people can't do that.....or.....are quite used to be alone.....
Passage 2 of 2 Section 0, Para 124, 101 chars.

124: so it's people involved with the interviews.........and can pick out personalities that can work.....

Node 21 Individual /respect/trust

112: they never say oh you're not qualified so you don't know that....or....it...everything is took on board.

Node 22 Client /patient role
Passage 1 of 1 Section 0, Para 184, 61 chars.

184: he's just a huge factor in that balloon in part of the team..

Node 23 Ideas of what joint working is
Passage 1 of 6 Section 0, Para 100, 53 chars.

100: everybody is a team and I think that's part of it....

Passage 2 of 6 Section 0, Para 108, 239 chars.

108: .I think some people come into the team and struggle to get that....concept that it is a team...and people work....closely with each other instead of being a lone person and you're out there and that's it...cos it doesn't exist that.......

Passage 3 of 6 Section 0, Para 112, 75 chars.

112: if we didn't all work closely the team wouldn't work.....I don't think....

Passage 4 of 6 Section 0, Para 116, 64 chars.

116: .I don't see how you can work as one person and the team be here

Passage 5 of 6 Section 0, Para 164, 61 chars.

164: just everybody in there...compact and everybody in there.....

Passage 6 of 6 Section 0, Para 188, 82 chars.

188: definitely not on the ground cos...we're not.....I think everything's just moving

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APPENDIX 8. DATA LISTED BY CODE

ON ACCOMPANYING DVD

To be found inside back cover of Volume 2.

APPENDIX 9. PARTICIPANT INFORMATION SHEETS AND CONSENT FORMS FOR STAFF AND PATIENTS.

The University Of Sheffield.

Department of Human Communication Sciences
31 Claremont Crescent
Sheffield S10 2TA UK

Head of Department
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Staff Information Sheet and Consent Form

Study Title

Interprofessional working with stroke patients in acute and community settings

- You are being invited to take part in a research study.
- It is important to understand what it will involve.
- Please read the following information carefully. Discuss it with others if you wish.
- Please ask if there is anything that is not clear or if you need more information.
- Take time to decide whether or not you wish to take part.

What is the purpose of the study?
The study is trying to find out how professionals work in teams to provide care for people who have had strokes. Team working and interprofessional working are thought to be the best way of providing care, but little is known about what exactly this means for the working health professionals, or the service users.

The study is trying to find out what exactly team working and interprofessional working mean. Are they the same way of working? If they are different, what is it that makes them different.
The study will be carried out over two years.

Why have I been chosen?
Four teams of professionals within South Yorkshire who work with stroke patients are being sought for this study. Individual team members are being asked to take part.

Do I have to take part?
- It is up to you to decide whether or not to take part.
- If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

What will happen if I take part?
- The researcher will select three patients that the team is working with. At selected points during a one week period she will observe professionals working with these

patients and be present at meetings and discussions where their care is talked about. The observations will focus on the way team members work together, how care is organised in the team, and the role that different professionals have. The researcher has no expertise in this clinical area so will not be making judgements regarding the quality of care offered by team members.

- You will be asked to take part in a short individual interview to seek your thoughts and views about working with other professionals. The interview will cover questions about the way the team works, your role in the team, and your thoughts on what attributes are needed to work in teams.
- You will be asked to report over the one-week period how much time has been spent working/discussing care with other professionals for the selected patients.

Will my taking part in the study be kept confidential?
- Information obtained by the researcher will be kept strictly confidential.
- Interview responses will be anonymous, and identities will be disguised in the research findings.
- Findings will only be reported as general feedback from all the sites studied, not on an individual team basis.

Who will have access to the research data?
Any tape recorded material will be transcribed by the researcher only. In addition, the two study supervisors only will have access to the data. You have the right of access to listen to your tape recorded material, and to keep and dispose of this material at the end of the study should you so wish.

What will happen to the results of the research study?
The study will form the basis of a PhD dissertation. Results of the study may be published in the future in the form of papers for journals, and may be presented at conferences. Identities of individuals and teams will be disguised in any report/publications.

Who is organising and funding the research?
The researcher is employed by the University of Sheffield. The work is being supervised by Dr Shelagh Brumfitt in the department of Human Communication Sciences, and by Prof Pam Enderby in the School of Health and Related Research.

Who has reviewed the study?
The South Sheffield Research Ethics Committee.

Contact Researcher
Sue Baxter
Dept of Human Communication Sciences
University of Sheffield
31 Claremont Crescent
Sheffield S10 2TA

Telephone 0114 2222436

THANK YOU FOR TAKING PART IN THE STUDY

You will be given a copy of this information sheet, and the signed consent form to keep.

CONSENT FORM

Title of Project: Interprofessional working with stroke patients in acute and community settings – pilot study

Name of Researcher: Susan Baxter

Please tick box

1. I confirm that I have read and understand the information sheet dated .1/10/04 (version 2) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time.

3. I agree to take part in the above study

Name of participant   Date   Signature

Researcher   Date   Signature

1 copy for participant; 1 copy for researcher;

The University Of Sheffield.

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Patient Information Sheet and Consent Form

Study Title

Interprofessional working with stroke patients in acute and community settings

- You are being invited to take part in a research study.
- It is important to understand what it will involve.
- Please read the following information carefully. Discuss it with others if you wish.
- Please ask if there is anything that is not clear or if you need more information.
- Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The study is trying to find out how professionals work in teams to provide care for people who have had strokes. Team working and interprofessional working are thought to be the best way of providing care, but little is known about what exactly this means for the working health professionals, or the service users.

The study is trying to find out what exactly team working and interprofessional working mean. Are they the same way of working? If they are different, what is it that makes them different? What is the patients experience of the ways that professional work together?
The study will be carried out over two years.

Why have I been chosen?

3 patients will be chosen from 4 different sites. The patients are selected to give a range of how the stroke has affected them, with some patients only mildly affected while others have been more affected.

Do I have to take part?

- It is up to you to decide whether or not to take part.
- If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.
- A decision to withdraw at any time or a decision not to take part will not affect the care you receive.

What will happen to me if I take part?

The care that you receive will not change.

- The researcher will observe professionals working with you, and be present at meetings and discussions where your care is talked about.
- You will be asked what you think about the way the team of staff works to provide your care.

Will my taking part in the study be kept confidential?

- Information observed by the researcher will be kept strictly confidential.
- What you tell the researcher will be kept entirely confidential.
- Your identity will be disguised in the research findings.
- Findings will only be reported as general feedback from all the sites studied, not on an individual team basis.

Who will have access to the research data?

Any tape recorded material will be transcribed by the researcher only. In addition, the two study supervisors only will have access to the data. You have the right of access to listen to your tape recorded material, and to keep and dispose of this material at the end of the study should you so wish.

What will happen to the results of the research study?

The study will form the basis of a PhD dissertation. Results of the study may be published in the future in the form of papers for journals, and may be presented at conferences. Identities of individuals and teams will be disguised in any report/publications.

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Who has reviewed the study?

The South Sheffield Research Ethics Committee.

Contact Researcher

Sue Baxter
Dept of Human Communication Sciences
University of Sheffield
31 Claremont Crescent
Sheffield S10 2TA
Telephone 0114 2222436

What if I wish to complain about the way in which this study has been conducted?

If you have any cause to complain about any aspect of the way in which you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms are available to you and are not compromised in any way because you have taken part in a research study. If you have any complaints or concerns please contact the lead study supervisor:

Dr Shelagh Brumfitt Tel: 0114 2222418

Or

You can use the normal hospital complaints procedure and contact the following person:

THANK YOU FOR TAKING PART IN THE STUDY

You will be given a copy of this information sheet, and the signed consent form to keep

CONSENT FORM

Title of Project: Interprofessional working with stroke patients in acute and community settings – pilot study

Name of Researcher: Susan Baxter

Please tick box

1.   I confirm that I have read and understand the information sheet dated .1/10/04
(version 2) for the above study and have had the opportunity to ask questions.

2.   I understand that my participation is voluntary and that I am free to withdraw at any time.

3.   I agree to take part in the above study

_____   _____
Name of participant   Date   Signature

_____   _____
Researcher   Date   Signature

1 copy for participant; 1 copy for researcher;