

**An exploration of culture and context for Allied Health  
Professionals using Care Aims in integrated community teams:  
A case study approach**

**By**

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## **ABSTRACT**

### **Background**

Integrated team working is increasingly being used a model of care within NHS Services. Whilst the integration agenda has evolved over time with increasing recognition of the continuum integration can refer to, consistent use of language and terminology has remained a challenge. The factors influencing integrated team working could be perceived as aspects of team, organisational and professional culture but there is a lack of studies formally assessing culture within an integrated team. Case studies also seldom appeared to include Allied Health Professionals with the reasons for this unclear.

Care Aims is also being increasingly used as a model of care within NHS services particularly by Allied Health Professions yet the evidence base appears sparse, particularly exploring the use of Care Aims in an integrated team.

### **Aim**

The overall aim of this study was to explore the effect of culture and context on integrated team working for Allied Health Professions in community settings.

### **Methodology**

This exploratory study took place in two parts. The first part of the study investigated the Care Aims approach and the effect of culture and context for integrated team working for Allied Health Professionals in primary care settings and comprises of four case studies.

The second part of the study evaluated and compared the case studies with other relevant models for promoting integrated team working for Allied Health Professionals (AHPs) in community settings.

Data collection were primarily qualitative using both questionnaires and semi-structured interviews based on the critical incident technique. The Team Climate Inventory (TCI) and Organisational Culture Assessment Instrument (OCAI) were used to explore culture and climate to provide supplementary contextual information. The individual case studies were analysed using thematic networks. Cross case analysis was employed to identify themes for comparison.

## **Findings**

The cross case analysis identified ten categories that appeared to influence integrated team working. Some of these categories were similar to themes identified in the literature exploring facilitators and barriers to integrated team working, such as leadership, staff roles and responsibilities, vision and professional culture. However different categories also emerged e.g. service type, team climate and relationship with the patient. The interdependency between the categories is also apparent, with philosophy and approach to care influencing all. Where there was a less dominant biomedical approach to care teams appeared to work in a more integrated way.

Similarly, Care Aims implementation appeared to be influenced by similar factors. The approach to care pre-Care Aims and how the introduction of Care Aims was managed appearing most significant. The findings also appeared consistent with the evidence base for managing change.

This study also suggested parallels between extent of integrated team working and success of Care Aims implementation. The more integrated a team appeared to be, the more successful Care Aims implementation also was. Whether level of team integration or introduction of Care Aims was the more significant factor is unclear.

One of the challenges of this study has been to identify other sufficiently detailed published case studies to enable comparative analysis. As a result of the comparative analysis in this thesis a framework for a minimum data set to enable cross case analysis of case studies exploring integrated team working is proposed. This will facilitate a better understanding of the evidence base. This study adds to the literature for integrated team working by exploring and comparing several integrated teams within the same organisation. Unlike previous studies, these case studies explicitly explored the role and impact for AHPs of working in an integrated team.

This study has also led to the development of a framework to support implementation of Care Aims by identifying the potential barriers and facilitators to implementing Care Aims. This could support teams to identify those areas which may benefit from greater attention and support during implementation. This study also adds to the limited evidence base for Care Aims by exploring the implementation and use of Care Aims in integrated teams and undertaking a comparative analysis of teams in the same organisation.

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During this journey, in addition to the subject matter of this study, I have learnt considerably about the research process, methods of data collection, qualitative data analysis and writing. I feel this will help me in the future to undertake research studies. The process of carrying out this study and the generation of qualitative data has been challenging but thought provoking.

This study has taken six years to complete and taken place at a time of great change both organisationally and professionally. At times it has been very challenging. It has helped me better understand both the challenges of studying and working but also the challenges of undertaking research in the workplace. I hope that I will be able to inspire and facilitate others, particularly AHPs to consider both studying at this level and to undertake research in the workplace.

## ABBREVIATIONS

|      |   |
|------|---|
| AHP  | Allied Health Professional                    |
| CIT  | Critical Incident Technique                   |
| EBCD | Experience based co-design                    |
| GP   | General Practitioner                          |
| HCPC | Health and Care Professions Council           |
| ICP  | Integrated care pathway                       |
| MPTW | Multi-professional teamworking                |
| NMC  | Nursing and Midwifery Council                 |
| NSF  | National Service Framework                    |
| OCAI | Organisational Cultural Assessment Instrument |
| OM   | Outcome measure                               |
| OT   | Occupational therapist                        |
| PCT  | Primary Care Trust                            |
| RA   | Rehabilitation assistant                      |
| SLT  | Speech and language therapist                 |
| TCI  | Team Climate Inventory                        |

## **GLOSSARY OF TERMS**

### **Allied Health Professionals**

Group of healthcare professionals working as autonomous practitioners. Includes professions such as occupational therapy, physiotherapy, speech and language therapy.

### **Autonomy**

Ability to make decisions and act independently and therefore be responsible and accountable for those decisions and actions.

### **Care Aims**

Model of care developed by Kate Malcomess. A person-centred approach that helps clinical decision making.

### **Care Programme Approach**

UK system of delivering community mental health services to people diagnosed with a mental illness.

### **Context**

The situation or circumstances within which something happens.

### **Emotional Intelligence**

The ability to identify and manage your own emotions and the emotions of others.

### **Groupthink**

Phenomenon that occurs within a group or team of people where the desire for harmony or conformity in the group results in an irrational or dysfunctional decision. Team members try to minimise conflict and reach consensus without critical exploration of a range of viewpoints.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Introduction**

This thesis presents the findings of a study exploring the effect of culture and context Care Aims for Allied Health Professionals (AHPs) working in integrated teams using Care Aims in community settings. This chapter offers an overview of the thesis and its structure.

A multiple case study design was used for this exploratory study. Data collection was primarily qualitative with the standardised assessment tools used to provide additional contextual information about team culture and climate. All the teams selected for the case studies were identified as using Care Aims (Malcomess, 2005a). The rationale being to select teams with similar models of care to facilitate cross case analysis.

#### **1.2 Justification for the Study**

At the start of this study in 2010 the literature search suggested that the majority of the evidence base exploring integrated team working tended to focus on team process rather than outcome or impact on service users (Blundell, 2010). Much of the research was based on the perception of professionals rather than service users and that which had involved service users was considering process rather than outcomes (Brown and White, 2006). The literature reviewed predominantly looked at integrated teams rather than integrated team working. Several case studies documented the barriers and challenges to integrated team working (Hudson, 2006a; Hudson, 2006b; Morrow et al, 2005; Syson and Bond, 2010; Tucker, 2010). However the literature reviewed suggested that often the teams in the case studies were at relatively early stages of development rather than well established and often alignment to change management theories was not discussed. These studies frequently included nursing and local authority (social care) staff working in services for adults and older people. The case studies seldom appeared to involve allied health professionals (therapists) with the reasons for this unclear. The findings of these studies appeared to support those of Cameron and Lart (2003) whose literature review explored the factors promoting and barriers to joint working and Maslin-Prothero and Bennion (2010) who reviewed

literature relating to integrated health and social care teams providing services for adults and older people in the UK.

The literature acknowledged that terminology and definitions of team working are used interchangeably and that there are multiple models of integration (McCallin, 2001; O'Neill and Cowman, 2008; Thylefors et al, 2005; Maslin-Prothero and Bennion, 2010).

Many of the studies exploring integrated team working referred to dimensions of culture such as leadership, involving frontline staff, clarity about roles, responsibilities and team purpose, without referring explicitly to organisational culture or the various theoretical cultural models. These dimensions were frequently identified in studies documenting the barriers and challenges to integrated team working (Hudson, 2006a; Hudson, 2006b; Morrow et al, 2005; Syson and Bond, 2010; Tucker, 2010). No studies could be found where the culture of an integrated team was assessed using a quantitative tool. Several of the case studies described the service model in some detail but did not appear to relate service model to theoretical frameworks.

In summary the literature review suggested the following gaps in the evidence base:

- Studies that feature allied health professionals working in integrated teams or delivering services in an integrated manner
- Comparative analysis of different approaches to integration
- Studies exploring integrated team working that look at outcomes for service users
- Assessing the culture within integrated teams using recognised cultural assessment tools
- The relationship between service model, culture, and outcomes.

### **1.3 Researcher's Relevant Experience**

Prior to starting this study I had some experience of undertaking research as part of programmes of academic study. This experience had been mainly using mixed methods and small scale studies.

At the start of this study I was a manager of several integrated teams working in community settings for a large community NHS Trust. Some of those teams included allied health professions. As an AHP myself I was curious about how different

professionals worked together and how this influenced the care that patients received. There was also increasing pressure to create more integrated teams as this was considered to improve outcomes for patients and also be more cost effective. However it was challenging finding relevant evidence to support this.

#### **1.4 Care Aims**

At the start of this study I was aware that Care Aims was being increasingly used as a model of care within NHS services, particularly by AHPs. Care Aims is a model of practice developed by Kate Malcomess (Malcomess, 2005b) which is designed to support practitioners demonstrate evidence-based practice through systematic reflection. The model focuses on impact of care, clarity of boundary of care, understanding clinical risk and clinical need. Malcomess (2015) acknowledges that adopting this model usually represents a change in culture and practice. The literature review found few published studies about Care Aims and none could be found in relation to Care Aims and integrated team working. I wanted to understand the impact of this model on integrated team working and whether it could help facilitate a favourable culture and climate for integrated team working. I wanted to explore whether the Care Aims model had the potential to facilitate integrated team working, by providing an opportunity for integrated teams to develop and agree more consistent working practices by exploring and agreeing their philosophical approach to providing care. This formed the basis of the first part of this study which specifically explores the Care Aims approach and the effect of culture and context on its implementation in an integrated team working in a community setting.

#### **1.5 Aim and Objectives of the Study**

The aim and objectives for the first part of the study were as follows:

Aim: To investigate the Care Aims approach and effect of culture and context for integrated team working for AHPs in primary care settings

Objectives:

1. To identify and understand the drivers for selection of the Care Aims approach by the organisation
2. To identify appropriate and relevant outcome and performance measures

3. To document implementation of the Care Aims approach through a range of prospective case studies using descriptive case analysis
4. To elicit the reported perceptions of team members, stakeholders and patients in relation to team type, role and function
5. To analyse the relationships between implementation, context, culture and outcomes.

The aim and objectives for the second part of the study were identified as:

Aim: To evaluate and compare the Care Aims approach with other relevant models for promoting integrated team working for AHPs in primary care settings.

Objectives:

1. To comparatively analyse the Care Aims case studies against theoretical and conceptual models
2. To comparatively analyse the Care Aims case studies against other empirical studies
3. To identify the impact of culture and context in various models for promoting integrated team working
4. To assess the relationship between model of working, context, culture and outcomes
5. To make recommendations for service planning to facilitate successful integrated team working for AHPs in Primary Care settings

However during the second phase it became apparent that comparative analysis with other empirical studies would not be possible as there appeared to be a lack of published case studies with sufficient detail to enable comparison. It was also decided to change the wording from primary care to community settings as community settings was felt to better describe where the teams were working. Although primary care is a reflection of community services with the NHS patient safety website (NHS, 2016) defining primary care as encompassing:

*“all healthcare taking place outside of acute and mental health trusts”.*

However often primary care can also be seen as:

*“the first contact between patient and medical practice, usually with general practitioner”* (Forsythe and Bromham, 1989, p.219).

Therefore the aim and objectives were revised to:

Aim: To evaluate and compare the case studies with other relevant models for promoting integrated team working for AHPs in community settings.

Objectives:

1. To comparatively analyse the Care Aims case studies and document the factors that appear to influence integrated team working
2. To comparatively analyse the Care Aims case studies and document the factors that appear to influence implementation of Care Aims
3. To assess the relationship between model of working, context, culture and outcomes
4. To make recommendations for future research to facilitate cross case analysis for integrated team working.

## **1.6 Organisation of the Thesis**

This section gives an overview of the thesis and structure and content of each chapter.

Chapter two provides an introduction to the literature and discusses the search strategies used to locate the literature. It explores and offers an appraisal of the literature looking at definitions and use of language, models of integration and teamwork, factors that appear to influence teamworking and integration, culture and context.

Chapter three introduces the Care Aims approach and explores the related literature. The use of terminology, models of integration and teamworking, culture and climate are appraised.

Chapter four gives an in-depth account of the research method and methodology. It provides a discussion about the rationale for the selection of method and methodology.

Chapter five describes the overall organisational context and presents the findings of the interviews with the managers. This chapter also reports the findings of the Organisational Cultural Assessment Instrument (OCAI) and the Team Climate Inventory (TCI) for each of the case studies including the pilot study. The measures of

team climate and culture giving an indication of the context that the teams in the teams were operating.

Chapter six introduces the four case studies. This chapter further describes the context for each case study and then reports the findings of each of the four individual case studies. The findings from the pilot study, identified as case study 1 are also included in this chapter.

Chapter seven marks the start of phase 2 of this study. It presents the cross case analysis of the four case studies using an approach described by Yin (2014). This chapter identifies and discusses the categories that emerged and were used to facilitate the cross case analysis. The categories are described and explored in detail in the context of integrated team working, comparing the case studies and appraising the findings in the context of relevant published literature.

Chapter eight presents the cross case analysis of the findings that relate to the implementation of Care Aims. Again Yin's (2014) suggested approach of use of word tables was used to facilitate the cross case analysis. The emerging categories and their impact on Care Aims implementation is explored and described.

Chapter nine describes the implications for practice, research and policy. It describes the contribution of the study to the evidence base and identifies areas for future research. The limitations of the study are discussed and also the impacts for practitioners, researchers and policy are summarised. This chapter offers a framework to support cross case analysis of case studies exploring integrated team working and also a framework to facilitate the implementation of Care Aims.

Chapter ten concludes this study and summarises the findings. As a result of the cross case analysis in this thesis a framework for a minimum dataset to enable comparative analysis of case studies exploring integrated teamworking is proposed. This will facilitate better understanding of the evidence base. A framework to support implementation of Care Aims is also suggested. The framework, by identifying potential barriers and facilitators to implementing Care Aims to enable teams identify areas which may benefit from greater attention during implementation.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Introduction to the Literature Search**

This chapter describes the search strategies used and explores the findings of the literature review relating to integration and team working.

#### **2.2 Policy Context**

Fragmentation of services has long been a concern for the NHS, particularly in terms of primary and secondary care and health and social care. In the 1990's the focus was very much on coordinated working, shared planning, care programmes and introduction of case management. The introduction of the care programme approach for mental health service users in 1990 particularly embedded all these elements and it is not surprising that much of the earlier integrated team working and integrated care literature relates to mental health teams.

During the 1990's inter-agency working, intermediate care and shared protocols became more popular. National Service Frameworks (NSF) were published by the Department of Health with the NSF for Mental Health launched in 1999 and the NSF for Older People launched in 2001. The Mental Health NSF (DH, 1999) described integrated care management and effective partnerships. The NSF for Older People (DH, 2001) specifically referred to developing more effective links between health and social services, integrated health and social care teams and joint multi-disciplinary teams. Although both NSFs identify roles for AHPs this does not appear to be reflected in the literature and is discussed further in section 2.3.

Over the next few years policy appeared to focus on more inter-professional working, whole systems working, integrated care pathways and the integration of health and social care. The 2008 review led by Lord Darzi (DH, 2008) also articulated the need for better coordinated, integrated and less fragmented services to improve person centred care and outcomes. This was followed by Equity and Excellence: Liberating the NHS (DH, 2010) and Integrated care: our shared commitment (DH, 2013) both of which signalled a shift towards a more person-centred approach with coordination of care rather than organisationally led integration. The Department of Health funded the

evaluation of 16 pilot sites across England starting in 2009 (RAND Europe and Ernst and Young, 2012), although most of the 16 pilot sites concentrated on health and social care integration. Several of the pilot sites have published aspects of their journey in the literature. These are included in the literature review in this chapter.

At the same time there was significant organisational restructuring taking place across the NHS in response to the policy documents including 'Creating a patient led NHS' (DH, 2005) and the Health and Social Care Act 2012. This led to the merger and creation of many new NHS organisations.

Most recently in the 'Five Year Forward View' (NHS England, 2014) integrated working continues to feature but with greater recognition that different solutions are needed for different communities and healthcare needs and that there are many options for providing integrated healthcare from person centred care to creation of new organisations.

### **2.3 Search Strategy**

At the start of the 1990s there were only a small number of documents published each year relating integrated team work in health, although this started to increase over the next 20 years. Even so when this study started in 2010 there was limited literature available to review (figure 2.1, p.9). This increased significantly for the next three years and appears to have started to decrease, since suggesting a potential correlation with government policy taking into consideration the period of time between a study starting and publication. An alternative explanation may be the increased recognition that integrated care and therefore integrated working require a range of solutions, such as the shift from organisational integration to more person centred which in turn impacts on the language used and in turn, a more diverse range of search terms is being used. For example integrated working is described less and collaboration more. Scopus, for example, searching with the parameters "Integrated AND team AND work\* AND health" (all English language) demonstrates the increase in literature (figure 2.1, p.9).

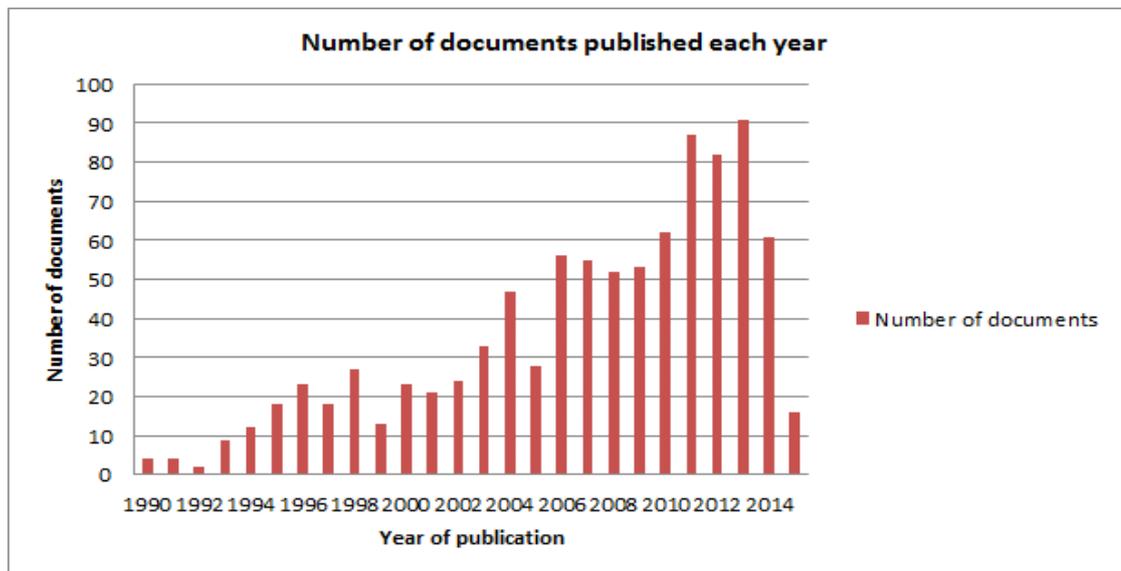


Figure 2.1 Number of published documents per year for search terms “integrated AND team AND work\* AND health” (all English language)

The results for integrated AND care AND health have a similar pattern although the volume of published literature is much greater by approximately 200%.

Several databases were used to carry out an online search for literature. No date limitation was adopted as there was limited literature prior to 1990 regarding integrated team working (figure 2.1, p.9). The bibliographic manager, Mendeley, was used in order to manage the large number of references. The databases used are listed below:

- AMED
- CINAHL Complete
- Ebrary Academic Complete
- Embase
- ProQuest
- Scopus

The literature search was compounded by the wide variation of terms and definitions used. These are discussed in more detail in section 2.4. This was not just in relation to integrated team work but other related terms as well including searching for profession related details e.g. use of AHP or profession specific title. Therefore a wide range of search terms was used. Examples of the range of search terms used are shown in table 2.1 (p.10).

Table 2.1 Examples of search terms

| <b>Date</b>   | <b>Database</b>               | <b>Search terms</b>  | <b>Number of documents</b> |
|---------------|-------------------------------|--|----------------------------|
| March 2010    | AMED, EMBASE, MEDLINE, CINAHL | integrated AND team AND work*  | 989                        |
| March 2010    | AMED, EMBASE, MEDLINE, CINAHL | integrated AND team AND work* AND allied AND health AND professional | 3                          |
| March 2010    | AMED, EMBASE, MEDLINE, CINAHL | integrated AND team AND work* AND therap*                            | 165                        |
| December 2013 | Scopus                        | Care AND aims  | 159,282                    |
| December 2013 | Scopus                        | Integrated AND team AND work* AND culture                            | 191                        |
| December 2013 | Scopus                        | integrated AND team AND work* AND care AND aims                      | 165                        |
| October 2014  | Scopus                        | profession AND hierarchy AND health                                  | 203                        |
| October 2014  | Scopus                        | profession AND identity AND health                                   | 718                        |
| October 2014  | Scopus                        | integrated AND team AND work* AND therap* AND health                 | 262                        |
| October 2015  | Scopus                        | care AND aims AND malcomess  | 2                          |
| October 2015  | Scopus                        | culture AND climate AND teamwork                                     | 167                        |
| October 2015  | Scopus                        | allied AND health AND profession* AND team                           | 801                        |

The largest producer of literature relating to integrated team working is the USA producing twice as many articles most years as the UK (source Scopus). This is of note as the different health and social care system may influence results particularly in relation to culture and climate. The impact of culture on interpretation of integration, integrated care and team working are discussed later in sections 2.4 and 2.8.

Much of the earlier literature appeared to relate to mental health. This is of significance as whilst AHPs do work in mental health teams, they are usually small in number and whilst their professional background may be that of AHP they are not always functioning in an AHP role but for example in a case manager role. Since

approximately 2010, an increasing proportion of published literature appears to relate to physical health primarily in older people, but again with limited mention of AHPs.

## 2.4 Definitions and Use of Terminology in the Literature

### 2.4.1 Definitions of Integration

Earlier on in this chapter changeable and varied use and breadth of terminology was identified as one of the challenges of the literature search. It is repeatedly recognised in the literature that there is no one common definition of integration and terminology is used inconsistently (Maslin-Prothero and Bennion, 2010). Within the collective evidence base there is great variance in use of terminology. For example Armitage et al (2009) found more than 70 terms and phrases related to integration giving about 175 definitions and concepts. Examples of definitions in use include:

*“the organisation and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money”* (World Health Organisation, 2008)

*“to express a very practical desire to make sure separate specialist healthcare services work closely together to ensure all a patient’s needs are met”* (DH, 2011 cited in Mental Health Foundation, 2013, p.8)

*“an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs”* (Goodwin et al, 2012).

Kodner and Spreeunwenberg (2002) exploring the roots of integration note the derivation from the Latin verb ‘to complete’ with the adjective meaning ‘reuniting parts of a whole’. Kodner and Spreeunwenberg conclude that:

*“integration is the ‘glue’ that bonds the entity together, thus enabling it to achieve common goals and optimal results* (2002, p. 2).

This appears to be quite a broad definition which also appears to bear a strong resemblance to the definition of teamwork described later in this chapter. The diversity and ambiguity of terminology may also be a reflection of not only the range and scale of integration from individual to organisational level, but also understanding of the continuum of integration. It is also possible that use of language reflects different perceptions of outcomes integration is expected to achieve.

More specifically for mental health, a briefing paper on integration and mental health for the Integrated Care Network (ICN) set out the policy context for mental health.

Appleton (2009) examines the challenges and opportunities for mental health and suggested that:

*“integration describes the coordinated commissioning and delivery of services and support to individuals in a way that enables them to maximise their independence, health and wellbeing. Coordination of this type is especially important for people with mental health problems who often require support from a variety of organisations or individual care workers. The delivery of integrated care is influenced by the practice of staff, the systems they work within, how users are engaged and the structure of organisations.”* (p.8)

In this last example not only is the continuum of integration cited in section 2.5 referred to but also the level of integration; whereas in the four earlier examples the descriptor is much more general supporting the view there is more than one type of integration.

However there are some authors who have attempted to differentiate between integrated care and integration. For example Shaw et al (2011) defined integrated care as:

*“an organising principle for care delivery with the aim of achieving improved patient care through better co-ordination of services provided”* (p.7)

And integration as:

*“the combined set of methods, processes and models that seek to bring about this improved coordination of care”* (p.7)

Therefore by these definitions integrated care could be perceived as the outcome and integration is the means; one of those means being integrated teamwork. This is consistent with the definitions of Appleton (2009) and Kodner and Spreeunwenberg (2002). This differs from the view of Lloyd and Wait (2005) reporting the findings of a workshop on integrated care suggest that integrated care is perceived as being about the means and not outcome. Lloyd and Wait (2005) further differentiate between the views of frontline staff and managers: for frontline staff integrated care was about working with other professionals to coordinate tasks and services across traditional boundaries and for managers it was about bringing together and managing targets and performance and a more diverse and larger group of staff. The report does not state who was present at the conference or how these views were obtained.

It is noticeable that many of the examples given earlier in this section (World Health Organisation, 2008; Goodwin et al, 2012) do not appear to focus on outcome perhaps reflective of the lack of evidence relating to outcomes of integrated care. This supports the views of Armitage et al (2009) who attributed the lack of understanding or clarity about the concept of integration as contributing factors to the lack of evidence about outcomes. They suggested that little had changed since 2002 when Kodner and Spreeuwenburg argued that the confusion and vagueness of definitions made it difficult to develop the evidence base, thus limiting progress in this field.

The challenge of consistent use of language and terminology is further compounded by the different types of integration described in various models such as clinical integration, professional integration, and functional integration. This is further explored in section 2.5.

Kodner and Spreeuwenberg (2002) also argued that terminology strongly influenced how we thought, developed and implemented health care highlighting the power of language. Another influence is culture, of which language is one aspect. Billings (2005) interviewed staff from different European countries to identify whether there was a shared understanding of integrated care, whether this varied between countries and whether the perceptions of staff were similar to the definitions used in published research. Billings (2005) found that understanding varied between countries supporting the view of Kodner and Spreeuwenberg (2002), demonstrating the impact of context and importance of terminology. This difference in understanding between countries is potentially significant. In section 2.3, it was identified that the largest producer of literature is the USA. It is unclear from the literature whether the different interpretations are influenced by the predominant health and social care systems or other factors such as culture. The potential influence of a country's health and social care systems is alluded to by Kodner and Spreeuwenberg (2002). They noted the differences between countries in their understanding of integrated care, giving the following example and questioning whether all of these interpretations are really integrated care:

*“it is most frequently equated with managed care in the US, shared care in the UK, transmural care in the Netherlands” (p.1).*

Wallace (2009) suggests that in the UK integrated care is known as intermediate care. Wallace (2009) further describes intermediate care as being about the management of long term conditions and admission avoidance. This definition of integrated care does have a partial focus on outcome by referring to admission avoidance and in the

continuum integration (table 2.3, p.19) this is the group of service users for whom Leutz (1999) suggested may have their needs best met through full integration. However by limiting integrated care to intermediate care and to service users aged 65 or over (Wallace, 2009) much of the population to whom integrated care may apply are excluded. This approach also appears to ignore earlier work in mental health services.

There was also a mismatch between how staff thought services should work and the desire for this to happen. Schein (2010) in his theory of implementing managed change described this as stage 1 of the change process where there is a need to 'unfreeze' the situation and create motivation to change. Change management and the impact of this on integrated teamwork is discussed further in section 2.5. However what was consistent was the centrality of the service user and their carers.

#### **2.4.2 Definitions of Teamwork**

Teamwork is also interpreted in a range of ways. Similar to integration there appears to be confusion and inconsistency over the definition of team type (McCallin, 2001; O'Neill and Cowman, 2008; Thylefors et al, 2005). Nancarrow et al (2013) in their review of interprofessional team working also found those terms were used interchangeably with the literature referring to both team types and their processes suggesting that little has changed during the last fifteen years.

In addition to inconsistent use of terminology for team types, Xyrichis and Ream (2008) identified that many papers discuss the concept of teamwork without first defining what is meant by teamwork and that there was no universal definition for healthcare settings and professionals in the published literature at that time. The definition of team working also appears to vary according to context e.g. organisational culture, national culture (Gibson and Zellmer-Bruhn, 2001) and professional culture (Cott, 1998; Thomas et al, 2003; Makary et al, 2006). Whilst multi-disciplinary and other types of teamwork are familiar concept to AHPs and taught as a core component of the undergraduate curriculum this did not appear to be recognised as a form of integrated team working in the literature.

Xyrichis and Ream (2008) define teamwork as:

*"A dynamic process involving two or more healthcare professionals with complementary backgrounds and skills, sharing common health goals and*

*exercising concerted physical and mental effort in assessing, planning or evaluating patient care” (p. 239)*

This is similar to the definition adopted by the World Health Organisation (2012) except with the inclusion of parameters by use of the term distinguishable:

*“a distinguishable set of two or more people who interact, dynamically, interdependently and adaptively towards a common and valued goal/objective/mission, who have each been assigned specific roles or functions to perform.”*

For the purpose of this study integrated teamwork is defined as a group of practitioners from different professions/sectors working together on a day to day basis, led by one person, usually based together.

## **2.5 Models of Integration**

In addition to the ambiguity regarding definitions there are different models and types of integration. There are also frameworks describing the intensity of integration: the integration continuum.

### **2.5.1 Conceptual Frameworks for Integration**

Probably the most quoted and widely recognised integration framework is that developed by Leutz (1999). Leutz (1999) developed a series of laws (table 2.2, p.15) based on his experience and comparison of attempts at integration within both the American and British health and social care systems. Whilst Leutz’s laws were acknowledge by Leutz himself (Leutz, 1999) to have no scientific basis they are widely recognised as principles for successful integration, supported by much of the literature (table 2.4, p.31) and described by Goodwin (2011) as “enduring truths”.

Table 2.2 Leutz’ laws of integration

|   |
|---|
| Law 1: You can integrate all of the services for some of the people, some of the services for all of the people, but you can’t integrate all of the services for all of the people. |
| Law 2: Integration costs before it pays   |
| Law 3: Your integration is my fragmentation   |
| Law 4: You can’t integrate a square peg and a round hole  |
| Law 5: The one who integrates calls the tune  |

It is unclear why Leutz' laws are so widely referred to but may be a reflection of their simplicity and resonance with the experience of those involved in different aspects of integration. However the majority of those who refer to Leutz would appear to be policy makers/commentators.

Theoretical frameworks of integration exploring different perspectives of integration have also been proposed by other authors. Building on the earlier work of Kodner and Spreeunwenberg (2002), Curry and Ham (2010) differentiated between three levels of integration: macro, meso and micro. Macro is where providers and or providers/commissioners deliver integrated care across the full spectrum of services to the population they serve; meso is where providers and or providers/commissioners deliver integrated care to groups of people with the same condition or disease and micro being to individual service users and their carers.

A similar model was developed by Lewis et al (2010) building on the earlier work of Fulop et al (2005) (figure 2.2, p.16) which not only describes the continuum and but also different types of integration. In this model, service integration includes integrated teams, suggesting that within the typology of integration lies a continuum of integration. However within the literature there appears to be little reference to these different typologies and the impact on integrated care or integrated team working.

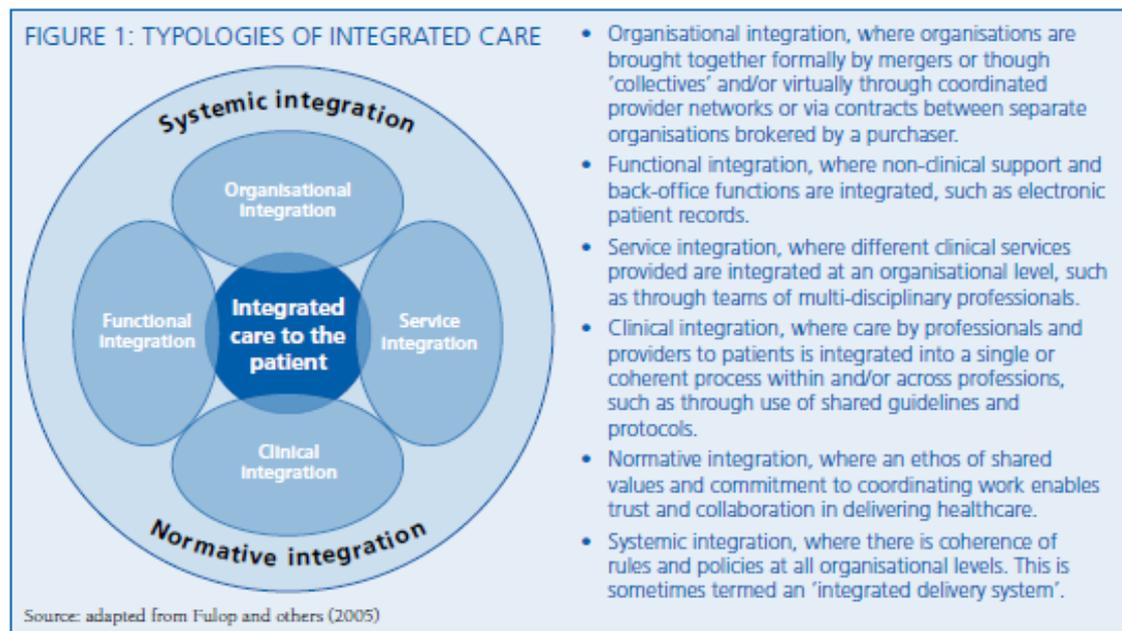


Figure 2.2 – Typologies of integrated care (Lewis et al, 2010)

Although there is a considerable amount of literature published on integration, very few studies test or refer to the different models of integration. This may also contribute to the inconsistencies and variation seen in the definitions of integration in the literature.

One of the models that appears to be evidence based is the Development Model for Integrated Care developed by Minkman et al (2009). This quality management model was developed following a literature review, Delphi study and concept mapping. It is also one of the few models that has also been tested (Minkman et al, 2011). The model was developed and tested in the Netherlands which may have implications for its use in the UK given the previous discussion about the variation in understanding and terminology between countries. Similarly the authors acknowledge that one of the limitations of the study is that it has been developed in one country and potentially reflects that country's healthcare system, values and politics. Similar to other studies the model has been developed without the inclusion of the service user's perspective although the authors do recognise this (Minkman et al, 2011). Where this model also differs from other models is that it is a quality management model and concerned with the development of integrated care explicitly rather than the actual provision of integrated care.

### **2.5.2 The Integration Continuum**

One of the best known continuum models and frequently quoted in the literature is that developed by Leutz (1999). This has been further developed by Shaw et al (2011) using the same continuum running from linkage to coordination to full integration (figure 2.3, p.18). Whereas Shaw et al (2011) appear to focus on operational issues such as organisational structure, budgetary control and information sharing; the model identified by Leutz (1999) appears to be more service user led. The irony being that one of four key lessons identified by Shaw et al (2011) is that *"the service user is the organising principle of integrated care"* (p.20).

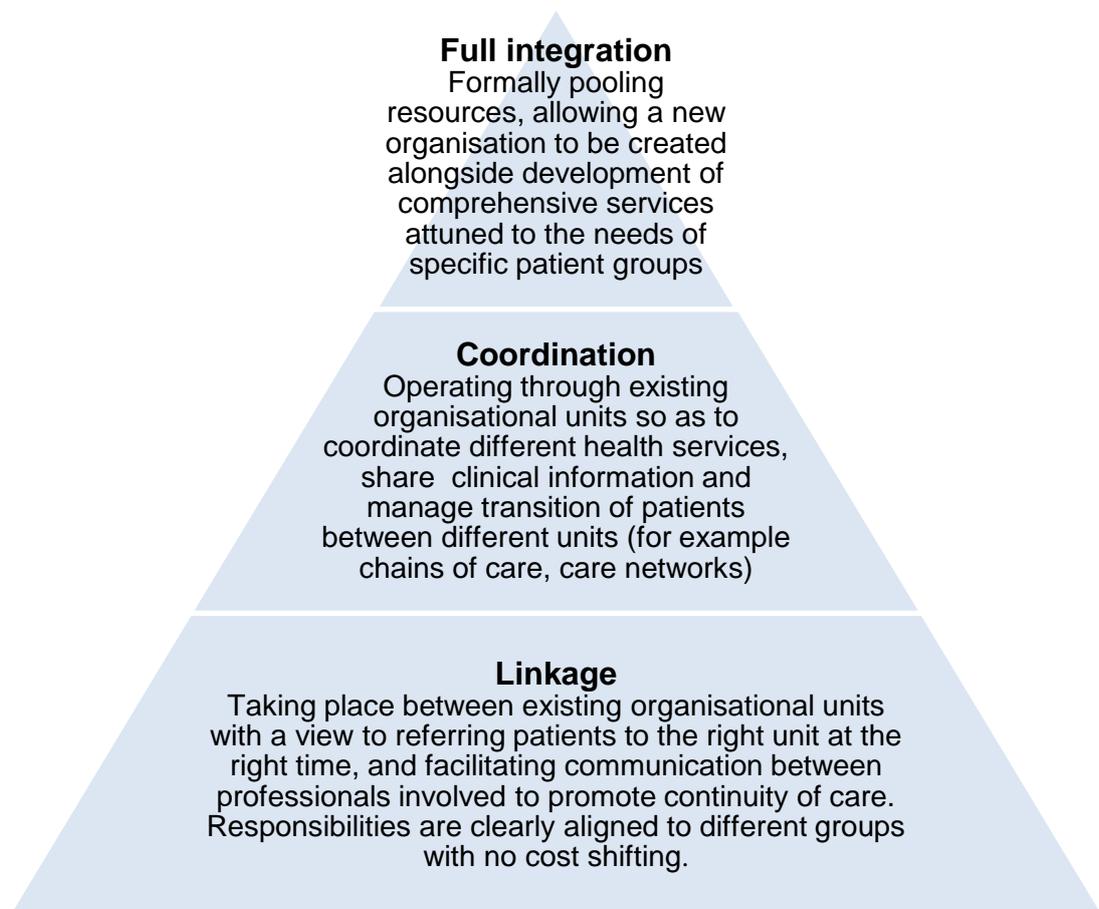


Figure 2.3 – Integration continuum (Shaw et al, 2011)

The continuum is built on the principle that the intensity to which services integrate depends on the needs of the service user with full integration working best for people with long term needs (Leutz, 1999). However it should be noted that this framework and the earlier work of Leutz (1999 and 2005) were in relation to health and social care integration (table 2.2, p.15).

Table 2.3 Matching service user needs to integrated care approaches (Leutz, 1999)

| <b>Client needs</b>   | <b>Linkage</b>     | <b>Co-ordination</b>   | <b>Full integration</b> |
|-----------------------|--------------------|------------------------|-------------------------|
| <b>SEVERITY</b>       | Mild to moderate   | Moderate to severe     | Moderate to severe      |
| <b>STABILITY</b>      | Stable             | Stable                 | Unstable                |
| <b>DURATION</b>       | Short to long-term | Short to long-term     | Long-term to terminal   |
| <b>URGENCY</b>        | Routine/non-urgent | Mostly routine         | Frequently urgent       |
| <b>SCOPE OF NEED</b>  | Narrow to moderate | Moderate to broad      | Broad                   |
| <b>SELF-DIRECTION</b> | Self-directed      | Moderate self-directed | Weak self-directed      |

Applying this framework to the type of work AHPs undertake may shed some light on where professions are more likely to engage on an integrated working spectrum and why it may be easier for some to engage in fully integrated working than others.

### 2.5.3 Integrated Care Empirical Studies

In the literature there appear to be few studies where the underpinning theory is explored or referred to, suggesting a possible lack of awareness, understanding or agreement with the supporting theory. This seems consistent with the findings of Minkman et al (2011) who noted the lack of a common set of factors for integrated care. Their study went on to generate 89 supportive factors care. This could be indicative of the breadth of influencing factors and possibly explain the apparent inconsistency between studies given the potential for so many different factors to be considered. This may also explain why no one model of integration appears to dominate or be recommended.

There does appear to be evidence supporting the various features that are considered to improve outcomes for service users. The evidence is varied and it is of note that no one piece of evidence supports all the features. Again this suggests support for the breadth of factors that influence integrated care. It also appears that many different fields provide the theory that underpins the application to integrated care. These are discussed below in more detail.

#### **2.5.4 Developing a Shared Narrative to Explain Why Integrated Care Matters**

The use of scenarios is similar in many respects to creating a vision which is a well-documented aspect in theoretical change management models such as Schein (2010). Similarly Greenhalgh et al (2004) proposed that if the benefits of an innovation are visible the innovation will be more readily adopted. Schein (2010) developed Lewin's theory further describing the need for enough 'disconfirming data' to cause discomfort (i.e. what's wrong with the current status) and connection of the disconfirming data to important goals and ideals (the new vision). Kotter (1995) identified that in every successful transformation he has seen "a guiding coalition develops a picture of the future that is relatively easy to communicate, appeals to customers, stockholders and employees" (p.98). This is also supported by Gilbert et al (2014).

The impact of vision and motivation to change on employees during change was developed further by Herscovitch and Meyer (2002). They developed a generic model to identify three types of commitment to change and therefore predict employees' behaviour at times of change. The three levels are:

- Affective commitment – a desire to provide support for the change based on a belief of its benefits
- Normative commitment – a sense of obligation to support the change
- Continuance commitment – a recognition of the costs associated with failure to support the change.

Use of scenarios is considered to help identify the benefits and potential ways to demonstrate and to also explore potential barriers to integration. For example Thistlethwaite (2011) reports the use of Mrs Smith, a fictitious user of health and social care services in Torbay to create a clear vision based on making a positive difference for service users and to monitor progress.

#### **2.5.6 Creating Time and Space to Understand New Ways of Working**

Studies have shown increased effectiveness of multi-professional team working where teams have been given time and space by their leaders to develop (Cameron et al, 2012; West et al, 2012). This is thought to enable teams to work through cultural and professional issues, negate stereotypes, to build mutual trust and respect and consider issues such as professional versus team accountability (Hudson, 2006a). It is acknowledged in the literature that developing integrated ways of working requires the

creation of a new culture and team climate and this takes time (DH, 2005; Gilbert et al, 2014). Creating time and space may influence the level of commitment towards new ways of working.

### **2.5.7 Build from the Bottom Up as Well as Top Down**

The literature demonstrates that organisational integration does not necessarily lead to integrated care as experienced by the patient (Curry and Ham 2010; DH, 2005). Kodner and Spreeuwenberg (2002) and Scragg (2006) both identify the importance of meaningful service user involvement to design services. Use of approaches such as Experience by Co-design (EBCD) has been shown to have several benefits:

- 19-22 months after implementation of 56 co-design solutions, 66% had been sustained;
- A follow up study in Australia 2 years after implementation reported that co-design had been shown to strengthen service provider and service user relationships. EBCD as a service improvement methodology had the ability to bring about operational efficiency and interpersonal care at the same time when compared to other methodologies (Kings Fund, 2013).

A more recent review of the Integrated Care and Support Pioneers Programme (Erens et al, 2016) also identified the most important factor affecting integration was the involvement of staff at all stages. This may also influence commitment to change as described in section 2.5.4.

### **2.5.8 A Single Point of Access to the Team, Single Point of Assessment and Close Alignment with Other Providers of Care**

In one of the few empirical studies, West et al (2012) identified that effective multi-professional team working is supported by the use of effective structures and processes in place such as single point of access. A single point of access, single point of assessment is recommended as good practice by a number of authors (CSIP, 2008; Cameron et al, 2012; Ham and Walsh, 2013) but these are not empirical studies. Gilbert et al (2014) also recommend that care pathways should be transparent to all stakeholders, with a clear point of access and enough flexibility to account for variations in presentation.

Experience from mental health services suggests that it is important to ensure that these specialist services do not become disconnected from other sectors including primary care (Gilbert et al, 2014) and that integrated services are aligned to other services particularly GPs (Ham and Walsh, 2013). This latter point appearing to address Leutz's law "your integration is my fragmentation" (Leutz, 1999). It is interesting that Leutz as a medic made this point particularly about doctors and Ham and Walsh (2013) have done too.

### **2.5.9 Co-location**

Co-location is commonly identified as a facilitator to integrated team working (Cameron et al, 2012; Ham and Walsh; 2013) mainly due to the increased opportunities for informal communication and to facilitate learning across professional boundaries. The Mental Health Foundation (2013) add the caveat that co-location is beneficial so long as staff understand their respective roles and responsibilities and work willingly and collaboratively together. The Team Climate Inventory (Anderson and West, 1996) specifically asks about contact between team members, sharing information and interaction between team members. Co-location would appear to support development of a positive team climate by the very nature of opportunity being provided for staff to meet and talk in both a planned and ad-hoc way.

### **2.5.10 Unified Management Structure but More Critically Alignment of Goals and Working Together**

Many of the earlier studies exploring integrated working identified that one of the barriers was where staff lacked clarity regarding goals or where organisational or team strategies were not aligned (Cameron et al, 2012). Whilst a unified management structure may facilitate integrated working, clarity and alignment of goals is more important. This is also supported by the findings of West et al (2012) in relation to effective team working. Similarly this also supports change management literature which describes the importance of a shared vision (Schein, 2010; Fuda, 2009).

### **2.5.11 Role of Clinical Leads as Change Agents**

Clinical leads are identified as integral to the change process (Ham and Walsh, 2013). Organisations with more clinical leadership are better at delivering change. Changes to work arrangements initiated by clinicians are more sustainable than those initiated

by managers alone (D’Innocenzo et al, 2014). Again this supports the findings of Erens et al (2016) about the importance of involving staff at all levels and stages.

#### **2.5.12 Knowing the Population Served – Use of Data to Stratify Population Needs and Target Resources Effectively**

Ham and Walsh (2013) identified that a key function of teams is to know the population they serve by making use of registries and other data sources, and to stratify the needs of this population in order to target expertise effectively. They note that risk stratification and case finding need to avoid the trap of focusing only on people currently vulnerable and seek opportunities to intervene early to support those who may become vulnerable in future. This indicates support for the model of matching level of needs with degree of integration (Leutz, 1999) shown in table 2.3 (p.19).

#### **2.5.13 Implementation of Effective Care Coordination**

Effective care coordination or navigation is identified as beneficial (Goodwin and Smith, 2011; Mental Health Foundation 2013). Personal contact with a named care co-ordinator and/or case manager is more effective than remote monitoring or telephone-based support (Goodwin et al, 2014).

#### **2.5.14 Integrated IT**

Effective and timely sharing of information is frequently identified as a facilitator to integrated team working (Cameron et al, 2012; Goodwin and Smith, 2011). Integrated IT often seen as the solution (Mental Health Foundation, 2013), although this is not seen as essential elsewhere (Goodwin et al, 2014). More critical is that information governance arrangements support appropriate information sharing (Ham and Walsh, 2013). These findings are also supported by the more recent evaluation of 14 sites as part of the Integrated Care and Pioneers Programme (Erens et al, 2016).

#### **2.5.15 Multidisciplinary Teamworking with Clear Roles and Responsibilities**

Understanding of roles and responsibilities is frequently identified as both a barrier and facilitator to integrated team working (Cameron et al, 2012; Johnson et al, 2003; Thylefors et al, 2005; Syson and Bond, 2010).

There is growing evidence that integration between teams may be more important than intra-team processes particularly in preventing silo working (Richter et al, 2006). Factors affecting inter-team collaboration including inter-group competition (West et al, 2012). This could potentially be linked to team culture although neither of these studies measured cultural type. Some cultural types such as in the Competing Values Framework (Cameron and Quinn, 1999) are identified as being more competitive than others.

### **2.5.16 Leadership**

Leadership is frequently cited in the literature as critical. Scragg (2006) identified that the personality of the team manager, rather than the professional background, was a key factor in their effectiveness and their ability to develop positive relationships with a range of staff from different disciplines. Scragg (2006) recommended that managers need continually to reinforce the vision of integrated working, with aims and objectives clearly communicated, understood and accepted by all staff, as a key element in strengthening the development of a shared culture. This is also supported by the findings of West et al (2012). Whilst their study explored community mental health teams it was carried out in the NHS, and some teams did include AHPs (mainly OTs).

Many of these studies appear to support the work of Leutz (1999) (table 2.2, p.15) although the supporting evidence base appears implied rather than explicit. For example there are instances in the literature where Leutz laws have been used to analyse an individual case study (Tucker, 2010) although they tend to be more widely used to explore and support theory and policy (Goodwin, 2011; Health Policy Insight, 2010; Leutz, 2005). Leutz's laws could also be applied to integrated team working but evidence of this being explored could not be found.

Whilst Leutz developed the laws mainly to address integrated working between health and social care (Leutz, 1999) Tucker (2012) identified that integrated care was more frequently found in health rather than health and social care services and was frequently delivered by multidisciplinary teams. Although often in the literature multidisciplinary working does not often appear to be recognised or acknowledged explicitly as a form of integrated working. This may be another example of where inconsistent use and understanding of terminology has potentially limited development of the evidence base.

Another example is the joint report of the findings of the DH integrated care 16 pilot sites (Rand Europe and Ernst and Young, 2012) where the term professional integration is used and defined as:

*“joint working; group practices, contracting or strategic alliances of healthcare professionals within and between institutions and organisations” (p.9.)*

This would appear to be different from clinical integration defined by Lewis et al (2010) (figure 2.2, p.16) in that the focus of professional integration is the workforce and in clinical integration the focus is the activities of integration. This could suggest that integrated team working (real or virtual) may be more likely to occur with clinical integration as opposed to professional integration as the vision, goals, roles and responsibilities are more likely to be clearly articulated rather than bringing together professionals into one organisation.

## **2.6 Models of Teamwork**

### **2.6.1 Conceptual Frameworks for Teamwork**

In section 2.4 the terminology used to describe different types of teams was shown to be used inconsistently. This also impacts on the various theoretical models in the literature. For example Thylefors et al (2005) identified three main models of teamwork in the literature on a continuum from multi-professional (multi-disciplinary) to interprofessional (integrative, interdisciplinary) to transprofessional. Boon et al (2004) identified a continuum with seven types. Both Thylefors et al (2005) and Boon et al (2004) appear to give similar definitions but the spectrum for Boon et al (2004) appears to also describe four earlier stages, each with reducing levels of integration. Alternatively Øvretveit et al (1997) suggested that as there is much confusion about the term multidisciplinary the term interprofessional should be used instead. In contrast their spectrum (Øvretveit et al, 1997) starts with a network (loose knit team) at one end with an integrated team at the other governed by a “multidisciplinary policy” (p. 11). Consistent throughout appears the recognition of a spectrum of integration for team working. Contrary to suggested government policy (section 2.2) Øvretveit et al (1997) considers different types of working arrangements for different purposes preferring to consider which type of working arrangement suits the needs of patient groups and available resources best. This appears consistent in principal with the thinking of Leutz

(1999) and Goodwin et al (2010) about which service users or types of service suit different degrees of integration (section 2.5), possibly addressing the perception of Thylefors et al (2005) who noted that the “*evidence base on which team type functions best is unclear*” (p.104).

In support of different team types suiting different purposes, there is evidence to suggest that whilst team working is effective and improves outcomes for service users, there are certain tasks that are best performed by individuals or groups of individuals working serially or in parallel (West 2012). West (2012) argues that to understand whether tasks are appropriate for teams the following should be considered:

- Completeness – whole tasks
- Varied demands – the task requires a range of skills that are best held/developed by a number of people
- Task requires interdependence and interaction
- Significance of the task
- Opportunities for team members to learn and develop
- The task can be developed
- Autonomy

This would appear congruent with thinking about integrated care and which patient groups and in which circumstances integrated care and team working are most appropriate and effective: the importance of context becoming increasingly apparent.

### **2.6.2 Integrated Team Working**

Similarities can be seen between the conceptual framework developed by Boon et al (2004) to describe the different types of team work delivering integrative health care and that developed by Shaw et al (2011) (figure 2.3, p.18). The different philosophy/values, structure, process and outcomes required dependent on level of integration described (figure 2.4, p.28). As the level of integration increases, professional autonomy decreases, there is a shift away from a biomedical approach and outcomes become more complex.

The ability of health professionals to work in a fully integrated way may vary and may be affected by differing operational models (Robinson and Cottrell, 2005). Supporting the theory proposed by Boon et al (2004), Robinson and Cottrell (2005) noted that health professionals valued autonomy and this may have impacted on their ability to

work in an integrated team. The teams in their study being multi-agency. Autonomy defined as:

*“the capacity to think, decide, and act on the basis of such thought and decision freely and independently” (Gillon, 1985).*

Autonomy and professionalism are discussed further in section 2.7.

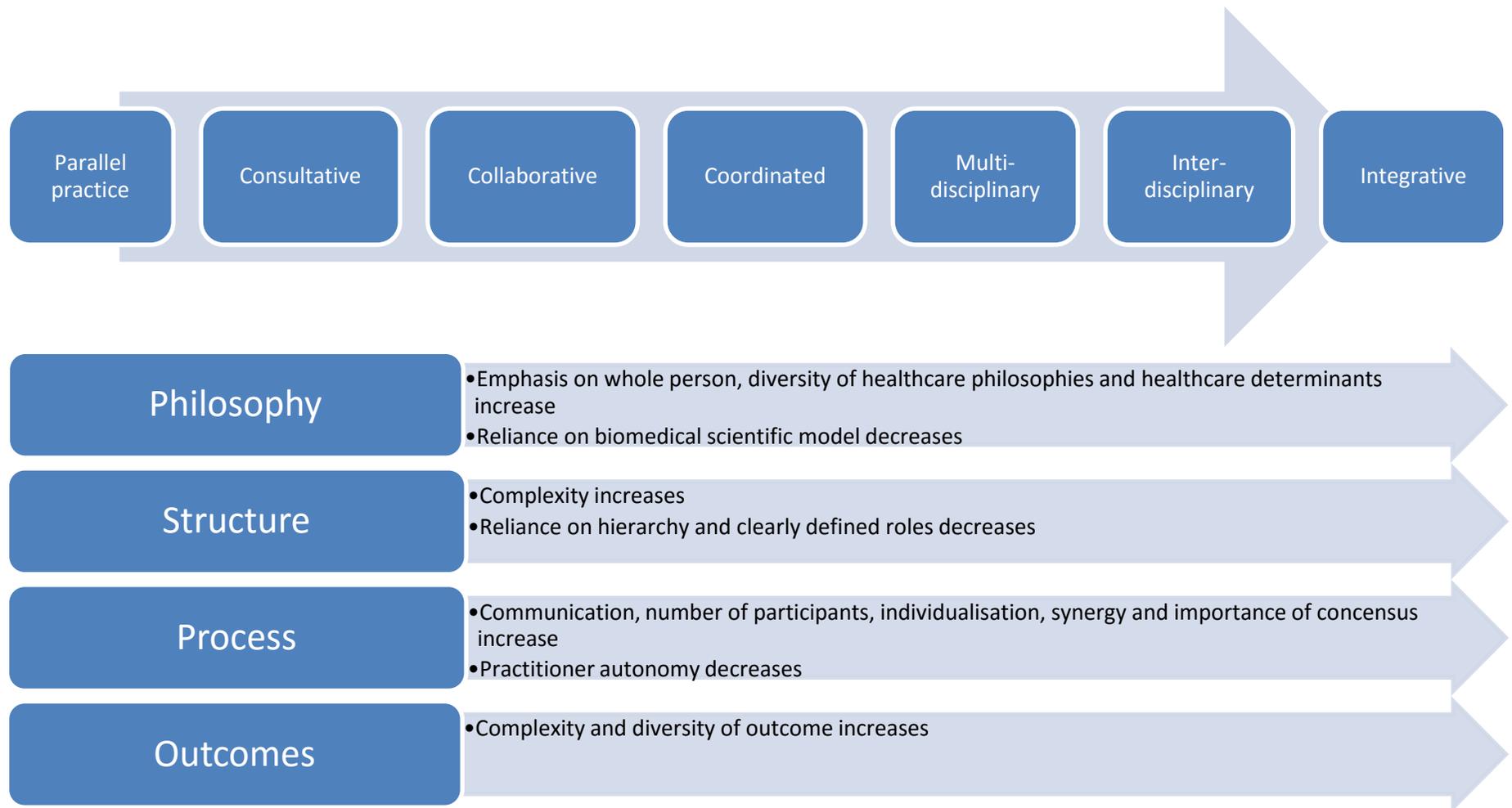


Figure 2.4 - Continuum of healthcare practice models (Boon et al, 2004)

The facilitators and barriers to integrated team working appear to be well documented (table 2.4, p.31) although many of these are based on the perceptions of professionals rather than the views of service users and also include literature reviews. Very few studies appear to consider outcomes for service users, one potential reason may be the challenging and long term nature of doing this (Erens et al, 2016).

The literature from which the barriers and facilitators to integrated team working were drawn (table 2.4, p.31) from included a number of case studies (Hudson, 2006a; Hudson, 2006b; Morrow et al, 2005; Syson and Bond, 2010; Tucker, 2010). It appeared whilst not explicitly documented that often the teams in the case studies were at relatively early stages of development rather than being well established and often alignment to change management theories was not discussed. There are similarities between the barriers and facilitators to integrated team working and change management theories such as the receptive contexts for change suggested by Pettigrew et al (1992) e.g. clarity and quality of strategy and objectives, leadership, co-operation and joint working. Another challenge that emerged during the literature review was the lack of detail in case studies to enable more critical appraisal and comparison of case studies.

Whilst the literature appears to identify common facilitators and barriers to integrated teamworking and delivery of integrated care there does not appear to be reported in the literature any factor that appears to be more significant than another.

Two different DH initiatives which between them covered 30 integration projects (RAND and Europe and Ernst and Young, 2010, Erens et al, 2016) both promoted integrated team working and delivery of integrated care. Both reported similar facilitators and barriers particularly relating to information sharing, roles and responsibilities and professional cultures. Significantly the latter initiative (Erens et al, 2016) appeared to have a greater focus on service user involvement particularly in developing the vision for integrated working in the fourteen sites. Of concern was that the more recent report (Erens et al, 2016) was not only reporting similar themes to those reported in previous years (Cameron et al, 2000 cited in Blundell, 2010) but that the identification of barriers to integrated working featured predominantly compared to facilitators in interview data. It should also be remembered that these were evaluations and not research studies.

Rather than looking at provision of integrated care, Nancarrow et al (2013) developed competency statements for effective interdisciplinary teamwork. They also note the

inconsistent use of terminology for team type and specifically note that they are using the term interdisciplinary as a generic term for healthcare teams including a range of professionals and skill mix. This would appear similar to the case studies in this thesis. The competency statements were developed following a systematic review and semi-structured workshops with teams. It is not surprising then that the characteristics are similar to the factors described by West and Lyubovnikova (2012) and previous literature summarised in table 2.4 (p.31). Where the study differs is that it includes reference to team climate and culture which many studies allude to but fail to specifically mention. The competency statement though is fairly generic:

*“interdisciplinary atmosphere of trust where contributions are valued and consensus is fostered”* (Nancarrow et al, 2013, p.6).

This is suggestive of both a positive team climate (section 2.7) and /or a clan team culture (section 4.6).

Overall it would appear that the principles for successful integration are well understood and desired but with varying arrangements and outcomes and that there has been no significant improvement during the last 20 years.

Table 2.4 – Factors supporting and acting as barriers to integration

| <b>Factors supporting integrated team working</b>                                   | <b>Barriers to integrated team working</b>  | <b>Reference</b>  |
|---|---|---|
| Mutual understanding and clear, realistic aims and objectives between organisations | Differences in organisational aims and objectives<br>Over ambitious aims and objectives             | Cameron et al (2000, cited in Blundell 2010); Royal Pharmaceutical Society of Great Britain and the British Medical Association (2000); Johnson et al (2003); Thylefors et al (2005); Gerrish (1999); Robinson and Cottrell (2005); Syson and Bond (2010) |
| Clarity about staff roles and responsibilities                                      | Lack of clarity about roles and responsibilities  | Cameron et al (2000, cited in Blundell 2010); Royal Pharmaceutical Society of Great Britain and the British Medical Association (2000); Brown and White (2006); Gerrish (1999);   |
| Organisational commitment to joint working  | Lack of organisational commitment or strategic support  | Cameron et al (2000, cited in Blundell 2010); Johnson et al (2003); Brown and White (2006); Cook et al (2001); Skidmore and Box (2009); Robinson and Cottrell (2005)  |
| Good communication and information sharing, including adequate IT systems           | Poor communication and IT systems   | Cameron et al (2000, cited in Blundell 2010); Royal Pharmaceutical Society of Great Britain and the British Medical Association (2000); Brown and White (2006); Morrow et al (2005); Cook et al (2001); Gerrish (1999); Gibb et al (2002)                 |
| Past history of joint working between the organisations                             | Political climate   | Cameron et al (2000, cited in Blundell 2010); Johnson et al (2003)  |
| Adequate resources  | Complex management systems, inadequate resources, financial uncertainty and frequent staff turnover | Cameron et al (2000, cited in Blundell 2010)  |
| Co-location   |   | Cameron et al (2000, cited in Blundell 2010); Brown and White (2006); Larkin and Callaghan (2005); Robinson and Cottrell (2005); Syson and Bond (2010)  |

| Factors supporting integrated team working  | Barriers to integrated team working  | Reference   |
|---|--|---|
| Involvement of front-line staff to create a sense of ownership<br>Team involvement in decision making |  | Cameron et al (2000, cited in Blundell 2010); Rees et al (2004); Skidmore and Box (2009); Workman and Pickard (2008)  |
| The 'right people' or personalities   | Professional identity/culture/tight role boundaries/negative professional stereotypes/professional differences | Cameron et al (2000, cited in Blundell 2010); Brown and White (2006); Thylefors et al (2005); McCallin and Bamford (2007); Skidmore and Box (2009); Robinson and Cottrell (2005); Gerrish (1999); Gibbon et al (2002); Larkin and Callaghan (2005); McCallin (2001); Morrow et al (2005); Brown and White (2006); Johnson et al (2003); Hudson (2007); Hudson 2006; Syson and Bond (2010) |
| Leadership  |  | Royal Pharmaceutical Society of Great Britain and the British Medical Association (2000); Johnson et al (2003); Brown and White (2006); Gibbons et al (2002); Outhwaite (2003); Skidmore and Box (2009); McCallin and Bamford (2007)  |
| Ongoing evaluation and monitoring   |  | Skidmore and Box (2009); Robinson and Cottrell (2005); Gerrish (1999); Gibbon et al (2002); Larkin and Callaghan (2005); McCallin (2001); Morrow et al (2005); Brown and White (2006); Johnson et al (2003); Hudson (2007); Hudson (2006b); Syson and Bond (2010)   |
|   | Constant reorganisation and instability  | Cameron et al (2000, cited in Blundell 2010); Tucker (2010); McCallin and Bamford (2007)  |

## 2.7 Culture

Many of the studies exploring integrated team working referred to dimensions of culture such as leadership, involving frontline staff, clarity about roles, responsibilities and team purpose without referring explicitly to organisational culture or the various theoretical cultural models. Only a few studies could be found where the culture of an integrated team was assessed using a quantitative tool (Bosch et al, 2008; Hann et al, 2007) but the main aim of these studies was to explore culture and team climate rather than integrated team working. It is also unclear from these studies where on the integration continuum the teams were. Alternatively Howard et al (2011) using the team climate inventory (TCI) found that culture, leadership and electronic medical record functionality rather than composition of the team and team size were the most important factors in predicting team climate in primary health care teams.

Cultural assessment tools are not commonly used in the NHS to assess culture (Mannion et al, 2008) despite culture appearing to be a common theme in several of the Department of Health's publications (DH, 2013a; DH,2013b). In the DH evaluation of 16 integrated care pilot sites, organisational and professional culture was identified as a challenge with the new management structures of integrated working described as feeling "foreign to some staff members more accustomed to more silo-type working" (RAND Europe and Ernst and Young, 2012, p. 105). One of the staff groups specifically mentioned was physiotherapists.

The value and application of cultural assessment tools is dependent on the philosophical approach adopted. For example in the context of change, culture can be regarded as either something that needs to be understood and used to implement change, or something that can be altered itself to bring about the change required. Culture can be seen as something an organisation is (often referred to as a root metaphor) or something an organisation has (a variable) (Smircich, 1983). Mannion et al (2008) noted that often it is hard to distinguish between the two approaches and that many researchers do not tend to commit to one or the other and place themselves somewhere between the two.

Where culture is seen as a something an organisation is, the focus is on understanding how people within an organisation create the culture and how the culture affects those that are part of it. For example in this paradigm managers and individuals within an organisation will be able to influence organisational culture to change it. There are three research traditions where culture is viewed as something an organisation is:

- a. The beliefs or assumptions of the members are the focus of study
- b. Language, non-verbal communication and other organisational symbols are the focus
- c. How symbols e.g. uniforms, offices reflect the underlying beliefs and assumptions of members.

Where culture is seen as something the organisation has, the focus is on cause e.g. it is thought that certain outcomes could be predicted and caused. For example in this paradigm managers would need to manipulate and work with the culture to achieve goals. NHS examples may include who can complete a particular form, how confidentiality is viewed, or who can do a particular task.

Therefore whether or not culture can be changed or whether it needs to be understood and used to influence change is dependent on one's philosophical perspective.

Culture can also be studied at different levels. Schein (2010) defines four:

1. macroculture e.g. national, ethnic and religious groups
2. organisational
3. subcultures e.g. occupational groups within organisations
4. microcultures e.g. teams within an organisation

Alternatively culture can be assessed from different perspectives or from different dimensions e.g. leadership or using typologies such as in the Organisational Cultural Assessment Tool (Cameron and Quinn, 1999).

It is probably not surprising therefore that similar to integration, culture has many variations in definition which Alvesson (2002) attributes to it being:

*“a tricky concept as it is easily used to cover everything and consequently nothing”* (p.3).

Within complex organisations such as the NHS it is recognised that a number of cultures will co-exist (Konteh et al, 2011; Schein 2010) with Mannion et al (2008) describing the NHS as *“notoriously tribal”* (p.16) mainly due to the dominant professional cultures particularly medicine.

Several studies also acknowledge that professional culture cannot be neatly separated from an individual's personal, social or professional history (Beales et al, 2011; Bonder

et al, 2002; Hammond et al, 2016) although there are also studies that suggest that as part of professional socialisation professional values override personal traits (Lai and Lim, 2012; Lorenc et al, 2014). In the few studies that specifically note the inclusion of AHPs in an integrated team, often they are very small in number e.g. in community mental health teams. One of the challenges this potentially presents is whether the attributes displayed should be assigned to professional culture or to the individual.

There is a growing body of research regarding the impact of organisational culture on professional work but little discussion of how professional culture co-exists with organisational culture (Khokher et al, 2009). Bloor and Dawson (1994) illustrate how a number of different professional cultures can co-exist and shape organizational culture and suggest that professions have cultures like organisations and these cultures are similarly have a history and context. Therefore if each profession has its own culture which exists as a subculture it is possible that integrated teams could include many more subcultures than a uni-professional team. Whereas culture normally provides members with a shared understanding, direction and purpose, the range and number of subcultures potentially operating within an integrated team may challenge this. This is supported by several studies (table 2.4, p.31) which have identified professional identity, professional differences and professional stereotypes as barriers to integrated team working (Skidmore and Box, 2009; Robinson and Cottrell, 2005; Gibbon et al, 2002; Larkin and Callaghan, 2005; Morrow et al, 2005; White and Brown, 2006; Hudson, 2006b; Hudson 2007; Syson and Bond, 2010).

### **2.7.1 AHP Professional Culture**

One of the studies that explored professional culture and team working explicitly (Beales et al, 2011) did include AHPs and found professional culture did impact on team performance with tensions between professional and the integrated team's culture and that a lack of meaningful structures and processes limited collaboration and integrated working. The study also recognised that collectively analysing AHPs as one group also masked the individual professional cultures. This is potentially an area for future research and would benefit from more in-depth exploration. The individual professional cultures are also recognised by Boyce (2001) when describing the need for AHPs to work together and urging them to reject the historical position of tribalism. Whilst the 10 key roles of AHPs include aspects that support integrated team working such as teaching other health and social care professions, developing roles which cross organisational and professional boundaries and "extending and improving

collaboration with other professions and services including shared working practices and tools” (DH, 2000) the extent of integrated working is limited to collaboration. Whether this is deliberate, or unintentional as Kodner and Spreeuwenburg (2002) suggested earlier, use of this language may inadvertently limit the extent to which AHPs integrate. However the impact of this may be influenced by whether the dominant professional identity is that of AHP or their individual profession.

As professional identity develops, personal identity is deemed to be less influential as the individual moves from exhibiting individual behaviour to exhibiting the collective behaviour of the group. As a result the perception of an individual as part of that group also increases their perception that they are different from other cultural groups. One aspect of being part of a professional group is the perception that the profession owns a particular body of knowledge and skills that only they possess so with increasing development of professional identity comes increasing autonomy and the need to progress individual rather than collective knowledge and skills. In the literature relating to integrated teams where AHPs are present in the team, often they are the sole AHP or in comparison to other professions in that team, low in number. On occasion the AHP group also appears to include nurses and social workers (Page et al, 2012). Whilst professional identity may be seen as a barrier to integrated team working, Dorahy and Hamilton (2009) argue that professional identity is necessary for the successful functioning of the team by the necessary differences and perspectives the different professions bring.

For example Wylie and Gallagher (2009) in a study exploring transformation leadership behaviours in AHPs identified significant differences between the professions with physiotherapists, occupational therapists and SLTs exhibiting consistently and frequently higher scores across the different transformational behaviour domains compared to dietitians, radiographers and podiatrists. The results suggested that physiotherapists, occupational therapists and SLTs showed more highly transformational leadership behaviours. They suggest that the nature of how OT, SLT and physiotherapists set goals with patients, on an individual basis rather than a more prescriptive process based approach may be a contributing factor. This could also suggest why OT, physiotherapy and SLT may be more able work in integrated teams.

In another example Maitland (2010) in his discussion about diagnosis notes the differences between professions and impact on care. He suggests there is a tendency particularly by AHPs to view diagnosis as defining professional identity and role; that is a judgement is made that in turn defines approach and interventions. By doing this uni-

professional working is reinforced. Maitland (2010) proposed redefining diagnosis to have a more generic interpretation which would then better facilitate integrated working as it would enable different professional perspectives to be encompassed. Maitland (2010) asks if it is possible “*to work towards common goals without an integrated characterisation of the patient’s health problem*” (p.308). This potentially may be one of the strengths of functional goal setting as discussed later, as function or a focus on impact may give a more shared description of the patient’s problems. This exploration of one aspect of care also supports the earlier discussion about the importance of language and terminology.

Three factors have been proposed as being important in influencing the level of control – real or perceived that one profession may have over another which in turn will impact on the ability of a profession to work in an integrated way (Halpern, 1992). These include:

1. the attributes used to compare professions,
2. the control one profession has over another and
3. a profession’s response to what is described as “*boundary infringements*” (p.25).

Bainbridge and Purkis (2011) reflecting on professional histories give the example that OT and physiotherapy were traditionally seen as a profession for middle class women to enter whereas nursing was associated more with the lower classes. The shift in gender balance within a profession is also influential in how a profession develops.

Increasing professional autonomy is closely linked to the development of a profession (Jones and Jenkins, 2006). Initially allied health professions such as physiotherapy and OT were identified as semi-professions with practice under the direction of doctors. As the professions developed with selective entry and ethical codes of practice, the forming of a distinctive knowledge, competency and skill set, autonomy increased. Rawson (1994) however notes that:

*“historically, professional autonomy is achieved through struggle and not simply granted ...professionalism mostly seen as strategies for closure of professional boundaries”* (p.47)

Professional autonomy may then be seen as something to be protected as it has been fought for. Rawson (1994) describes the weakening of professional autonomy through reduced professional body involvement in education and training and changes to professional regulation. Role extension, more patient centred and integrated working

practices may possibly be seen as further erosion of professional autonomy. Part of working in a fully integrated way requires the professional to act as a partner in care rather than a director of care; the professional has to share their knowledge with the patient to facilitate the patient's decision making and ability to choose. This may also influence compliance: in a biomedical model, compliance would be assumed with potentially sanctions applied if not (Pearson et al, 2003).

## **2.8 Professional Culture and Integrated Teamworking**

Whereas a biomedical (or scientific) model of health is based on knowledge about the biological causes of disease and focusses on curing. It is also thought elitist with the clinician considered to have superior knowledge and perceived to be expert, rational and scientific. By contrast patients are considered to be ill-informed and their role devalued (Teijlingen, 2005).

If we return to the model proposed by Boon et al (2004) (figure 2.4, p.28) where practitioner autonomy and reliance on a biomedical model decreases with increasing integration it is understandable why integrated teamworking may be more challenging to some professions than others. Add to this the potential range of professions and therefore subcultures; in an integrated team the complexities of integrated teamworking are apparent. Many of the case studies reported in the literature also appeared to relate to 'young' or newly formed teams (Hudson, 2006a; Scragg, 2006; Syson and Bond, 2010; RAND Europe and Ernst and Young, 2010) although frequently this is implied rather than explicit. The relevance of context is therefore strongly reinforced.

Bloor and Dawson (1994) note that professionals are more likely to articulate their professional values when they perceive the organisational environment to be uncertain which may be the perception in a newly formed team. Beales et al (2011) support this, noting from their study that even though healthcare professionals appeared to support interprofessional working because the team in this instance was relatively new and still developing they drew on their previous experience which is often a uni-professional culture to make sense of what was happening. However even in more established teams where the professions may be more closely aligned, the impact of professional cultures may be apparent. Nancarrow (2004) exploring role boundaries in what appears to be an established intermediate care team, identifies that even where tasks are shared which may have previously been the domain of one particular profession; how they approached the task appeared to be influenced by the professional identity of the individual.

This is also supported by Pecukonis et al (2008) who suggests that each profession tends to set itself apart from others, positively viewing their contribution compared to others, implying an element of competition rather than the collaboration needed for integrated team working. There is evidence to suggest that whilst interprofessional health education programmes can change students attitudes and increase their understanding of the roles of other members of the health care team this is not long lasting (Giordano et al, 2012). Although from the literature it was often unclear how experienced staff in teams were.

The potential impact of professional identity and culture is summarised succinctly by Mickan and Rodgers (2005):

*“Ignorance, competition and jealousy often reinforce inaccurate professional stereotypes, which ultimately limit effective teamwork if left unchecked”* (p.359)

## **2.9 Influence of Experience and Seniority on Integrated Teamworking**

The seniority of the staff involved was a supportive factor in enabling integrated team working (Nancarrow, 2004). Conversely newly qualified staff may also struggle. One explanation may be the requirement to share sufficient information with the patient as described earlier and newly qualified staff may be less confident doing this and also accepting the choices patient's may make. Nancarrow (2004) suggests that newly qualified staff may be at risk of losing their professional identity and experience role ambiguity if they work in teams with high role overlap. Conversely newly qualified AHPs may have a different perception of their professional identity as inter-professional education is more embedded in pre-registration training than it possibly was in 2004 (Baxter and Brumfitt, 2008). The uncertainty surrounding role identity may arise from the experience on graduating that actual practice does not reflect their learning (Martin and Rogers, 2004) or the experience summarised by D'Avray and McCrorie (2011) who observe that:

*“profession centric behaviour tends to be the norm, with each profession holding its preferred view of the world that is reinforced by training”* (p.128).

## **2.10 Context**

Similar to integration, teamwork and culture, context is widely referred to but with varying definitions. For example context is defined as the situation or circumstances within which something happens (Macmillan, 2016). Pettigrew et al (1992) refers to

context in relation to change, influenced by both internal and external factors. This underpins their receptive and non-receptive contexts for change which was developed following exploration of change in NHS organisations. Testing of Pettigrew et al's (1992) model by Newton et al (2003) found the most significant factors to be:

- The quality and coherence of policy
- Availability of key people leading the change
- Supportive organisational culture
- Effective managerial-professional relations
- Co-operative inter-organisational networks
- Simplicity and clarity of goals and priorities.

The similarities between these factors, the factors supporting and acting as barriers to integrated team working (table 2.4, p.31) and the features that support better integrated care outcomes for service users (section 2.5) can be seen.

Weiner (2009) argues that there are other contextual factors that affect readiness for change such as organisational culture. Denison (1996) refers to team climate as a situation, suggesting that climate and context may be the same. He also suggests culture is an “*evolved context*” (p.644) within which climate may be embedded which, despite the differing theoretical basis of culture and climate, both give greater understanding of context in organisations. On a more basic level it may be the physical environment where health services are delivered (Thomas et al, 2011).

Context is important, as understanding it helps minimise the likelihood of failure when replicating solutions from one organisation into another and wondering why failure occurs (Bate et al, 2002). West et al (2012) explored context specific factors affecting multi-professional team working (MPTW). They found that organisational context was very influential and also went on to describe various supporting factors which could be aligned to culture and climate. Alimo-Metcalf et al (2007) also identified a range of contextual factors that affect MPTW performance for Mental Health teams and also identified that contextual factors can have a greater impact than leadership on team performance. One of the contextual factors was organisational support. This lends support to the views of Ferlie and Shortell (2001) and Robert and Fulop (2012) who suggest that studying the interactions between contextual factors at all levels in the organisation is important.

In another example Thomas et al (2011) exploring the organisational factors facilitating research based practice in AHP departments found that implementation of research in practice was influenced by context in addition to individual practitioners. Interestingly they also found that there was little evidence of collaboration across professions. Ten Hoeve et al (2014) in a discussion paper exploring nursing professional image argued that context also influences professional identity, possibly inferring that professional identity may vary between organisations. This also suggests that we should not assume that professional culture is the same in every organisation, challenging the assumption that barriers to integrated team working attributed to professional culture may be attributable to other factors present.

There are many aspects to context and the effect of context on research results can vary from subtle to significant (Johns, 2006). Within the evidence base for integrated team working and delivery of integrated care there appears to be increasing recognition of the role of context. It is increasingly acknowledged that there is no one solution or panacea.

## **2.11 Summary**

It would appear that over time the integration agenda has evolved with greater recognition and perhaps acceptance of the continuum covered. Despite, or perhaps because of this, the challenge of defining integration and integrated team working remains. Whilst there are few AHP-specific references in the integrated care/integrated team working literature, there is greater mention in the literature attributed as multidisciplinary or interprofessional working. The irony is that this does not appear to be acknowledged as a form of integrated team working in the literature.

The factors affecting successful integrated team working are similar to those for team working. However the breadth and variety of professions working in an integrated team may exaggerate and magnify the potentially many differences in culture including team, organisational, professional. Given the often small numbers of AHPs in integrated teams the influence of personal rather than professional identity should not be forgotten.

The ability or readiness of AHPs to integrate may be influenced by their need for professional autonomy and also the context within which they are operating. Team

development and management of change will also influence and be influenced by context which in turn are affected by culture and climate.

## CHAPTER 3

### CARE AIMS

This chapter introduces the Care Aims approach developed by Kate Malcomess (Malcomess, 2005b). It presents my understanding of Care Aims and reviews published literature about Care Aims.

#### 3.1 Introduction

Care Aims was developed by Kate Malcomess in the mid 1990's whilst working as a therapy manager to support decision-making in her team (McCarthy et al, 2001; Malcomess, 2015) and would appear to be a practitioner based approach. Since then it is reported Care Aims has been:

*“widely adopted across the United Kingdom, especially in the field of speech and language therapy with many services stating that they base their practice on this model”* (Stansfield and Matthews, 2014, p. 21).

Stansfield and Matthews (2014) provide supporting examples such as commissioning guidance, speech, language and communication publications and job descriptions drawing to the conclusion that Care Aims is *“well respected and widely used”* (p.21). On her website Malcomess (2015) identifies that more than 20,000 practitioners in more than 180 teams across over 80 organisations have been trained. Settings where Care Aims is identified as being used include inpatient settings, community neurology, rehabilitation, mental health, learning disabilities and special educational needs. However the results of a survey exploring goal setting practices in community based stroke rehabilitation teams by Scobbie et al (2015) would suggest otherwise. They found only 1% (five from 380 responding services) reported using Care Aims to support goal setting practice. This is discussed further in section 3.5.

#### 3.2 What is Care Aims?

Care Aims is described as a model, framework and philosophy by Malcomess (2015). Early literature describes Care Aims as:

*“a means of defining the purpose of intervention of health care”* (McCarthy et al, 2001, p.505).

However later studies appear to reflect a range of interpretations including:

*“A tool that captures reason to treat”* (John, 2011, p.41)

*“A procedure...to enable a transparent and consistent approach to caseload management”* (Stansfield, 2012, p.171)

*“an approach to eliciting goals and aims”* (Murphy and Boa, 2013, p.10).

Malcomess (2005a and 2005b) describes Care Aims as a model underpinned by a framework for clinical decision-making using clinical need, clinical risk, and duty of care as the basis for decision making. There are tools to support assessment of clinical risk and need. For example to support decision making at the triage and assessment stages there are admission and treatment indicator profiles; to support reasoning about the level of clinical need a client has i.e. how much time will be required to achieve the identified outcomes there is a clinical need indicators profile and for overall caseload management there is a caseload profile tool (dependency grid). Each episode of care is classified with a ‘Care Aim’ which summarises the purpose of that episode of care. The eight original Care Aims were: assessment, maintenance, anticipatory, enabling, curative, rehabilitation, supportive and palliative (Malcomess, 2005a). By 2009 these and the decision making flowchart had been revised with the ‘Care Aims’ labels, descriptors and the questions being asked as part of the decision making process all changing (Malcomess, 2015) . There still remained eight Care Aims which were renamed:

- investigation
- prevention
- stabilization
- participation
- resolution
- improvement
- adjustment
- comfort.

Unchanged was each episode of care having goals agreed with the service user, clear outcomes and a specified start and finish date.

Care Aims is described as being different from traditional approaches where the focus is on problem solving based on the patient's presenting condition, to one that considers the impact on the person as a whole (Malcomess 2015). This is described by Malcomess (2005b) as a shift from what you are doing to why you are doing it. Malcomess (2015) provides a comparison of Care Aims with a medical model of care (table 3.1, p.46). Parallels can be seen between Care Aims and integrated team working (section 2.6.), particularly the model described by Boon et al (2004) (figure 2.4, p.28). For example both Care Aims and integrated team working appear to place the emphasis on the person as a whole, patient centred approach, collaboration and rejection of a biomedical model of care.

Table 3.1 Comparison of Care Aims with a medical model of care (Malcomess, 2015)

|                                    | <b>PREVAILING PHILOSOPHY AND APPROACH IN ACUTE AND OUTPATIENT MEDICAL CARE</b>  | <b>CARE AIMS PHILOSOPHY AND APPROACH</b>  |
|------------------------------------|---|---|
| CLINICAL REASONING FRAME           | Uses a Problem-based frame for decision-making around admission, assessment, treatment and discharge. Overall population needs are considered at a very broad level e.g. number of beds.  | Uses a Duty of Care frame around admission, assessment, treatment and discharge based on risk, predicted clinical effectiveness and clinical need. Takes a whole-population approach to these decisions.  |
| RISK ASSESSMENT                    | Uses condition-risk as the predominant frame for risk assessment  | Uses impact/forseeable impact for the person as the frame for risk assessment   |
| CLINICAL INTERVENTION AND APPROACH | Direct intervention is the preferred approach with limited investment in pre-referral activities  | Supporting self-help and universal services through consultancy is the preferred approach to a request for help from a referrer or member of the public   |
| EVIDENCE-BASE FRAME                | Use efficacy as their main reference for clinical effectiveness   | Acknowledges efficacy as the first point of evidence but uses a predominantly effectiveness approach to evidence-base   |
| APPROACH TO CLINICAL OUTCOME       | Predominantly uses process measures and measures of patient status at the end of care to evidence clinical outcome. Where clinical outcomes are being measured they are not predicted first, so a status measure against baseline will be the most common approach. | Uses prediction of change within an identified time-scale to support evaluation of clinical outcome and clinical effectiveness. Uses different measure for each predicted outcome (i.e. each Care Aim) and the focus is on the degree to which the outcome has contributed to reducing or avoiding the impact on the patient. Uses PROMS and other related outcomes to evidence outcome of universal and targeted work. |
| DEGREE TO WHICH CARE IS            | A lot of care is process driven using ICPs or other task-based guidelines. Very few of the  | The approach is entirely person-centred to support reasoning around impact and outcome. The 8 Care  |

|                                     | <b>PREVAILING PHILOSOPHY AND APPROACH<br/>IN ACUTE AND OUTPATIENT MEDICAL CARE</b>  | <b>CARE AIMS PHILOSOPHY AND APPROACH</b>   |
|-------------------------------------|---|--|
| PERSON-CENTRED CARE                 | ICPs use any impact-based reasoning in the decision-making required to plan care.   | Aims do not make sense unless the focus is person-centred. Whilst it recognises the need for ICPs this is at a task level and not a reasoning level and it supports departing from the ICP if it is not reducing the impact. |
| CASELOAD/<br>WORKLOAD<br>MANAGEMENT | Prioritisation is based on condition-risk with the highest condition-risk clients prioritised over any other patients. Consideration of clinical effectiveness is limited when prioritising cases. Throughput or discharge are normally not a problem as patients are usually managed in relatively uniform packages of care. | Uses clinical effectiveness and level of need (resource) as the basis for prioritising cases and managing throughput.  |

In 2015 when Malcomess re-launched Care Aims as the “Care Aims Intended Outcomes Framework”, Care Aims was described as a:

*“powerful approach to service improvement... based on a population and person-centred philosophy which focuses on fundamental ethical principle” (Malcomess, 2015).*

The rationale for the change was expressed due to Care Aims:

*“being perceived as a model of practice rather than an overarching reasoning and decision-making framework” (Malcomess, 2015).*

Malcomess (2015) appears to acknowledge that this previous ambiguity may have been due to her own use of language and terminology. Use of terminology such as ‘model’ could be perceived as reinforcing diagnostic or condition based thinking which would appear to be at odds with the philosophy and approach described in table 3.1 (p.46). Malcomess (2015) also reported that Care Aims had been described as an outcome measure, which it is not.

### 3.3 Search Strategy for “Care Aims”

Several databases were used to carry out the online search for literature relating to Care Aims. A date limitation was not adopted as the model was only developed in the mid-1990’s. A range of search terms was used to discover Care Aims related literature and to exclude literature that included only the words ‘Care’ and ‘Aims’ as this uncovered thousands of unrelated articles. The terms used are shown in table 3.2 (p.48).

Table 3.2: Examples of search terms used

| <b>Date</b>   | <b>Database</b> | <b>Search terms</b>                             | <b>Number of documents</b> |
|---------------|-----------------|---|----------------------------|
| December 2013 | Scopus          | Care AND aims                                   | 159,282                    |
| December 2013 | Scopus          | integrated AND team AND work* AND care AND aims | 165                        |
| October 2015  | Scopus          | care AND aims AND malcomess                     | 2                          |

In 2010 there was very little published literature relating to Care Aims. Whilst published work since then appears to be still sparse there have been several more publications in the last 5 years. The lack of published literature regarding the introduction or use of Care Aims was also identified by Stansfield and Matthews (2014). The search was then extended from peer reviewed journals to “grey literature” including items of professional forums and newsletters. With Care Aims predominantly used by AHPs, this lack of published research may be reflective of the wider AHP research culture (Janssen et al, 2015, Thomas et al 2011).

In addition all the literature that was found was generated in the UK suggesting that Care Aims may not be recognised outside the UK. This is supported by Snomed CT (the systemised nomenclature of medicine clinical terms – clinical phrases or terms used in the NHS for coding) stating that Malcomess Care Aims model is a ‘*UK specific concept*’ (NPEX, 2016). Possible explanations for this could be the lack of published studies including use of Care Aims in other healthcare contexts outside of the UK; that Care Aims is a taught model only available from Malcomess Consultancy potentially limiting spread; or a reflection on the dominance of other professions such as medicine and nursing and a dominant biomedical model of care. Also Care Aims has its origins in the allied health professions which is acknowledged to be less dominant and contributions often marginalised compared to medicine and nursing (Petchey et al, 2013; Oliver, 2015). Even within the allied health professions there is huge variation in terms of conformity to the biomedical paradigm with radiographers and physiotherapists at one extreme and arts therapists at the other (Petchey et al, 2013). This could potentially limit the appetite for some professions to explore use of Care Aims. For a practitioner to be able to implement Care Aims not only is organisational support required but the practitioner must be sufficiently autonomous. For example in some European countries the status of physiotherapists is viewed differently and they work less autonomously and independently than physiotherapists in the UK (Trueland, 2011).

### **3.4 Application in a Uni-professional Setting**

The earliest publication found in a peer reviewed journal described an audit of how Care Aims was being used in Speech and Language Therapy teams in the South East of England (McCarthy et al, 2001). In this audit results were primarily from paediatric teams (69%). Whilst the audit report claimed that health outcomes had been improved, no evidence to support this could be seen in the report as the results appeared to

report outputs rather than outcomes. Examples of the data reviewed included whether therapists were using Care Aims, which Care Aims were most frequently used and whether episodes of care were being completed with different types of patients. Malcomess (2005) stated that there is considerable case by case evidence of the impact on practice yet at this time there were very few published studies. Malcomess called for more rigorous evaluation to be undertaken yet it appeared to be some time before further studies were published. There appears to be a ten year gap between the article by McCarthy et al (2001) and the next by Mowles et al (2010) being published. This may be reflective of the research culture in allied health professions where there appears to be a rapid change in service delivery models that is not reflected in peer reviewed publications for multiple reasons (Metcalf et al, 2001).

Care Aims is mentioned in a review of therapy outcome measures by John (2011) where it is identified as a tool that captures the reason to treat. The next study was published in 2012 where Stansfield evaluated the referrals and episodes of care in a speech and language therapy service for adults with learning difficulties focussing on those who are parents. Whilst it was identified that the service used Care Aims, the study was not about Care Aims but explored referral patterns, reasons for referral and types of contact.

Two reviews of services for children with speech, language and communication needs made little mention of Care Aims (Roulstone et al, 2012; Smith et al, 2010). However a review measuring outcomes in augmentative and alternative communication (Murphy and Boa, 2013) did identify Care Aims being used as an outcome measure (OM). However, these authors later go on to say that:

*“Care Aims was mentioned many times, but it was agreed that this is not an OM (more of a process).”* (p. 26).

The initial view of Care Aims as an outcome measure would also appear to support the rationale given by Malcomess (2015) for changing the name of Care Aims.

Millar et al (2013) described how waiting times and provision of care were improved in an occupational therapy service following adoption of Care Aims. The service was reported to have started using Care Aims in 2006. Whilst waiting times were shown to have reduced significantly and overall numbers of children seen have reduced, there appeared to be no evidence in terms of outcomes or perceptions of service users. In many services a reduction in the overall number of patients seen would be seen as a negative result. In this study it was suggestive of successful implementation as

inappropriate referrals were not accepted and the duty of care approach was being applied in line with the Care Aims approach.

In summary, the uni-professional studies reviewed seemed to report process outputs rather than any of the rigorous evaluation that Malcomess invited (Malcomess, 2005). The uni-professional studies have also been in professions where the biomedical model is less dominant. This supports the earlier view (section 3.2) that Care Aims sponsorship and uptake may be limited to those professions where there less dominance and allegiance to the biomedical paradigm.

### **3.5 Application to Integrated Teamworking**

More recently there have been three studies where Care Aims is used in integrated teams. One reports the findings of the pilot study in this project (Waterworth et al, 2015) (appendix 11) and the second reports the introduction of Care Aims to a multidisciplinary adult learning disability service. Similar to the study by Waterworth et al (2015), Stansfield and Matthews (2014) report the perceptions and views of staff who were also generally positive about Care Aims in supporting clinical practice. The third reports the findings of a survey exploring goal setting in stroke rehabilitation (Scobbie et al, 2015). This latter study appears to contradict the views stated earlier (Malcomess, 2015) that Care Aims is widely used. In these teams only 5 of the 380 services responding were found to be using Care Aims to guide goal setting. However 82% of these services were multidisciplinary teams and speech and language therapy teams were present in 64%. Whilst the results do not specify the makeup of the teams who reported using Care Aims, the results suggest that Care Aims is less used in other professions than in Speech and Language therapy as suggested by Stansfield and Matthews (2014).

The comparison of Care Aims with a medical model of care in table 3.1 (p.46) suggests that Care Aims has many similarities to the model for integrated teamworking described by Boon et al (2004) (figure 2.4, p.28). This indicates that Care Aims has the potential to support integrated team working. Whilst Waterworth et al (2015) supported this view, the findings from their case study were inconclusive as to whether it was implementing Care Aims or the development time to support Care Aims implementation that enabled the integrated team in their case study to work more effectively as an integrated team.

### **3.6 Perceptions of the Care Aims Approach**

Section 3.3 reported the inclusion of “grey literature” in the Care Aims literature search due to the lack of peer reviewed literature. It was decided that it would be reasonable to explore the internet more widely looking at “grey literature” for perceptions of how Care Aims was viewed nationally and locally. A general topic search was undertaken to obtain contextual and background information. This yielded links to the Malcomess Care Aims website.

More specific questions such as ‘is Care Aims effective’ produced little additional information. Use of different search engines such as Google and Yahoo showed little variation in results. This is defined as derived information when searching for information from the internet i.e. questions are defined but the answers is not typically contained in a single web page or website (Stacey and Stacey, 2004). Potential reasons for this include no motivation to share; difficult to share and unable to share. In light of the earlier comments about AHP research culture it is possible that in this instance reasons for the lack of information available outside of the Malcomess website is due to all three of those reasons. It is also possible that a significant proportion of grey literature will be on professional forums where access is limited to members only thus limiting the availability of internet based information to those outside a particular profession. This too may impact on the spread of Care Aims to other professions and countries.

### **3.7 Rationale for Focus on Care Aims in this Study**

Care Aims had been implemented in my organisation for several years when this study was initiated. The organisation, as reported in chapter 4 had undergone significant change but was still aspiring to rollout Care Aims across more teams. At the same time more integrated teams were being established in line with national and commissioning policy.

I had also been involved in the introduction and implementation of Care Aims with several uni and multi-professional teams in the organisation. Whilst I had seen results prior to 2010 similar to those later reported by Millar et al (2013), there appeared to be little peer reviewed literature relating to Care Aims and none related to integrated team working and Care Aims. My own observation was that whilst many of the features of Care Aims appeared compatible with integrated team working, there was also potential

for professional differences and interpretation of duty of care to negate this. Care Aims appeared to have the potential to facilitate the cultural identity described by Petch (2014) which:

*“transcends the traits of particular professions or individuals and provides the most effective basis for the delivery of integrated provision and the achievement of organisational and individual outcomes” (p.8).*

### **3.8 Summary**

This chapter has presented my understanding of the Care Aims approach. It appears that the published evidence base is limited with the majority of published literature relating to uni-professional settings and in professions where the biomedical model of care is less dominant. Care Aims could be perceived as a management model as there would appear to be very limited evidence to demonstrate the development of the approach and underpinning theory.

There also appears to be very limited evidence reporting the use of Care Aims in integrated teams. Although Care Aims appears to have similarities to integrated team working theoretical models, the use of Care Aims in integrated teams appears to have been little explored or reported. This may be a reflection of integrated team working literature seldom mentioning mention AHPs and Care Aims potentially being perceived as an AHP derived approach.

By exploring and comparing the impact of Care Aims in several integrated teams, this doctoral thesis will add to the limited body of literature regarding Care Aims implementation and investigate its application in integrated teams.

## **CHAPTER 4**

### **METHODOLOGY AND METHODS**

#### **4.1 Introduction**

This chapter describes the methodological approach and method used to carry out this study.

This study comprised of two parts – phase 1 and phase 2. The aims and objectives each phase are detailed in section 1.5. Phase 1 explored the Care Aims approach and effect on culture and context for integrated team working for AHPs in primary care settings and phase 2 evaluated and compared the case studies from phase 1 with other relevant models.

#### **4.2 Design Considerations**

An exploratory approach was used as it was felt to be the most appropriate due to the lack of research about the Care Aims approach: the aim of the research was to investigate the Care Aims approach and effect of culture and context for integrated team working for AHPs in community settings. An exploratory approach is considered useful when the topic is new and problems are in a preliminary stage and there are few or no earlier studies to which references can be made for information (Sim and Wright, 2000).

This study uses a qualitative approach which historically has tended to predominate in cultural studies (Mannion et al, 2008). This is supplemented by the use of two standardised assessment tools to facilitate contextual comparison of the culture and climate in each case study. Mannion et al (2008) in one of the largest studies measuring and assessing organizational culture in the NHS recommend using both quantitative and qualitative approaches to benefit from the strengths the different paradigms provide. This is explored further later in this chapter.

Both ethnographic and positivist methodologies were also considered. An ethnographic approach was rejected due to a pragmatic rationale as I aimed to explore the implementation of the Care Aims approach in several teams. The aim and objectives in this study were more descriptive rather than a clearly defined hypothesis

as would be expected with a positivist approach. There are cultural assessment tools available (Scott et al, 2001) that produce a numerical score and therefore permit statistical analysis. However this approach was considered to not provide the depth of understanding being sought and particularly limiting exploration of the impact of context.

Longitudinal studies were considered compared to cross-sectional designs but rejected due to the potential future impact of organizational change in a rapidly changing organisational context (section 2.2). A longitudinal study would potentially have focused on one team with the findings possibly being influenced by the individuals in the team rather than the use of Care Aims. Also the number and range of AHPs in the team may have been limited. A cross-sectional design was used as this gave the opportunity to include more teams in the study and gain a better representation of the range of AHPs in teams.

This study is more aligned to the constructivist approach which acknowledges that truth is relative and dependent on one's perspective (Baxter and Jack, 2008). One of the strengths of case studies is the use of multiple sources of data collection. In this study questionnaire, interview and documentary data were collected, results triangulated and then synthesized.

The study comprises of a series of case studies as this was felt to be most appropriate due to the exploratory methodology and exploring a current situation within its real-life context in some depth (Yin, 2014). To facilitate access to teams and completion of the study I chose to ask teams from my employing organization to participate. This also ensured that teams had received a relatively consistent approach to the teaching of the Care Aims approach. However I was conscious that there was potential for my position within the organisation to influence the outcome and therefore the inclusion criteria included that the team was not directly or indirectly managed by me. This immediately excluded 12 of the 24 teams in the organisation which were engaged in Care Aims learning and implementation at that time. I intended to complete case studies with up to 4 teams as this was felt a sufficient number of teams to enable comparison but which could also meet the inclusion criteria. The two most limiting criteria were identifying teams where I did not have a management relationship and teams not undergoing any other major service change. A list of teams who had completed the Care Aims training was provided by the organisation. Purposive sampling of teams took place to explore contrasting characteristics and context. As described in section 2.2 and later in section 5.2, there was considerable organisational change occurring

with many teams being restructured which excluded them from being considered for this study. Teams also needed to meet the inclusion criteria and have the agreement of the service manager to participate. The teams were all community based, providing a range of specialist services and range in size between 8-30 staff. All staff were employed by one NHS Foundation Trust. The inclusion criteria are shown in table 4.1 (p.56).

Table 4.1 – Inclusion criteria for case study teams

|  |
|--|
| <p><b>Teams:</b></p> <ul style="list-style-type: none"> <li>• The majority of team members have completed the full Care Aims training</li> <li>• The team includes Allied Health Professions</li> <li>• The team is not undergoing any other major service change e.g. merging with another team</li> <li>• The team manager is supportive of the research project and able to provide access to team members, team members time to fully participate in the study and willing for their team’s patients to be approached</li> <li>• The team is not directly or indirectly managed by the researcher</li> </ul> |
| <p><b>Patients:</b></p> <ul style="list-style-type: none"> <li>• Patients are able to give informed consent for themselves in order to participate in the study</li> <li>• Patients are willing (or in the case of dependent patients both they and their carer are willing) to participate in the study</li> <li>• Patients started their episode of care after the team introduced using the Care Aims approach</li> <li>• Patients understand English sufficiently to give informed consent and complete the questionnaire e.g. do not need an interpreter to access their treatment.</li> </ul>              |

Another design consideration was the order in which to approach teams with respect to how long they had been practicing Care Aims. The decision was made to approach teams in the order in which they completed the Care Aims training to promote consistency across the case studies. This also enabled teams who were relatively new to Care Aims the opportunity to embed Care Aims prior to data collection and also make the case studies more comparable. However it became apparent that due to several planned organizational changes this was not going to be possible and a more pragmatic approach was required.

### **4.3 Case Study Research**

For phase 1 data collection, four exploratory case studies were undertaken. The aim of exploratory case studies was to attempt to understand what happened, looking beyond descriptive features and studying the surrounding context (Yin, 2014). Exploratory case studies are often conducted in an attempt to define research questions and hypotheses. Yin (2014) identifies that a case study is the method of choice when a better understanding of real-life scenario is wanted and it is assumed that the context is relevant and important.

This study was about the effects of culture and context on integrated team working for allied health professionals. Case studies were chosen because the cases were the teams the AHPs worked in and they could not be considered without the context of the wider team, the organisation and the patients they interacted with. This together gave a truer picture of the impact of culture and context.

Multiple case studies were identified rather than single case studies in order to provide more evidence to support theory building (Eisenhardt, 1989).

### **4.4 Critical Incident Technique**

The Critical Incident Technique (CIT) was the method selected to inform questionnaire and interview design following a review of the literature. CIT was selected because it was recognised as a method of analysing culture (Mannion et al, 2008), advocated as a method for studying inter-professional work as decision-making (Rawson, 1994), and had been employed in studies within healthcare and educational settings (Bendtsen et al, 1999).

CIT was developed by Flanagan (1954) and there are five stages. The first part of the process is to formulate the general aim of the activity to be studied as a prerequisite for evaluation of specific behaviours (positive and negative). My study is exploring the Care Aims approach and effects on culture and context for integrated team working for AHPs in primary care setting and will also look at how the Care Aims approach is being implemented and used in these teams.

Stage II involves looking at who should be the observers (respondents) and which activities should be noted. Flanagan (1954) suggests that observers should be chosen

on the basis of familiarity with the activity and their ability to make firsthand observations. In my study it was felt appropriate to identify more than one group of observers so I asked team members, managers and patients to be the observers/respondents. The activities relate to how the Care Aims approach is or was being implemented and from the patient's perspective the care they received as a result of the Care Aims approach being used. For example one of the questions in the team member's questionnaire asked them to describe a time when they used the Care Aims approach. Supplementary questions asked how they felt about it, what they were thinking and what the outcome was. Questions in the patient questionnaire include asking them to describe the situation or event which they observed or experienced which is something that impressed them as an example of effective care by the team or person treating them. Follow-up questions asked them why this was particularly effective what was helpful and also how they felt and what they hoped would happen next.

Stage III is about collecting the information (figure 4.2, p.70). In the studies reviewed information was collected in a range of ways (Kvarnstrom, 2008; Kemppainen, 2000; Jordan, 1996; Atwal, 2002; Heijkenskjold et al, 2010). This included individual interviews, focus groups, questionnaires, and assessment by observation carried out by the researcher. I decided that I would use questionnaires as the first way to collect information as I thought this would elicit a better response rate from both staff and patients, and would allow people the opportunity to decide whether they wanted to opt in or out of completing the questionnaires or taking part in interviews and also support anonymity. I also thought the questionnaire would allow people time to think about their responses in a non-pressurised way. However the information provided might not be detailed enough so on the questionnaire respondents were asked to indicate whether they would be willing to take part in a semi structured interview. I also felt that initially using questionnaires would facilitate a greater response rate compared to conducting interviews alone and this was the case with the pilot case study. Questionnaires were coded e.g. A1, B1 so that it was clear which team the responses referred to.

Stage IV is analysing the information. Most of the studies reviewed using CIT used inductive classification of information into categories which enables descriptions of information into different levels of specificity or generalisability and initially I planned to use content analysis to analyse the data (Sim and Wright, 2000). Following discussion with supervisors this was progressed to the use of thematic networks and follows the process described by Attride-Stirling (2001). This enabled a more systematic and consistent approach to data analysis as well as facilitating cross case study

comparison. Yin (2014) identifies the importance of clarifying the unit of analysis as the start of the case study. In this study the unit of analysis was the team.

Step five is reporting the findings. The individual case studies are reported in chapter 6 and the cross case analysis findings are reported and discussed in chapters 7 and 8.

CIT is considered a culturally neutral method (Gremler, 2004) because participants are invited to share their perceptions of an issue rather than indicate their perceptions to a researcher-initiated question because there is no prior determination of what will be important and both positive and negative incidents will emerge. It is reported to be context-rich and usually participants have good recall as they talk about specifics rather than generalities, providing a broader understanding of the culture within the context it is applied (Jung et al, 2009). The analysis of CIT enables the researcher to relate context, strategy and outcomes, to look for patterns and commonalities in themes and gives a good picture of the relationship between context and outcomes. This technique is particularly useful when exploring unknown phenomena so is well suited to an exploratory methodology (Gremler, 2004). Mannion et al (2008) in their review of culture and assessment tools used in the NHS, said that due to the complexity and changing nature of cultural research in this field, needs to be naturalistic, taking place in real-world settings and making careful note of the mediating role of contexts. CIT was considered an appropriate way to do this.

However CIT is a retrospective research method and relies on events being remembered by respondents and requires them to be accurate and truthful in reporting them. An incident may have taken place some time before the data is collected. CIT has been criticised as the design of the method has potential for recall bias (Gremler, 2004) although a counter argument could be that by the nature of the interviewee being asked to recall a 'critical incident' this is potentially reduced: the interviewee is being asked to recall an event that is of significance to them. In addition respondents may not be accustomed or willing to take the time to tell or write a story when describing the incident (Edvardsson and Roos, 2001). There was also potential for researcher influence bias, due to my position as a manager within the organization. The inclusion criteria specifically address this. CIT also asks the interviewee to identify the incident they wish to discuss rather than an incident chosen by the researcher which also possibly reduces researcher influence on responses. Another source of bias may come from the perceived length of time to complete the questionnaires/interviews.

Analysis of documentary evidence such as case notes and meeting minutes were used to facilitate triangulation of data and to check factual statements from interviews with team members and patients. The study complied with Caldicott principles, ensuring confidentiality and security of patient related data. Case notes were not reviewed due to the lack of patients opting in and giving consent for this.

#### **4.5 Questionnaire and Interview Development and Design Considerations**

The objectives described in section 1.5 led to the topics that the questionnaires and interviews needed to address and which group of respondents the topics would be relevant to. For example, the first objective was to identify and understand the drivers for selection of the Care Aims approach by the organisation. It was decided that this would be included in the questions managers were asked (appendix 1) but not team members (appendices 2 and 3) or patients (appendices 4 and 5).

The objectives lead to the following topics being addressed in the questionnaires and interviews:

- Implementation of Care Aims
- Perceptions of team type, role and function
- Outcome and performance measures
- Organizational drivers for selecting Care Aims as an approach to care

In addition to the Critical Incident Technique, the literature review of integrated team working and integrated care also informed the design of the questionnaires and interviews for both staff and patients.

It was also important that the questionnaires and interviews for each team started with questions that were considered less threatening but also easy for team members to answer. It was decided in the team member questionnaires and interviews to ask about what the team did, what sort of team it was and their role in the team. The literature had identified that the level of integration varied with patient group and type of intervention (section 2.5); that the level of integration varies according to team type (section 2.6); clarity about role and responsibility is a barrier and facilitator to integrated team working (table 2.4, p.31).

It was decided to then ask about implementation of Care Aims and a time when Care Aims was used: the incident given to describe use of Care Aims indicating perceptions of Care Aims and also extent of implementation.

It was decided to ask more personal demographic information at the end of the questionnaire but to limit these to a few areas only: age of respondent, band (grade of post), and length of time in the team. The literature suggested that seniority is a supportive factor for integrated team working (Nancarrow, 2004; Beales et al, 2011) (section 2.9); the tension between professional and team culture related to experience as a practitioner and team member (section 2.8); and potential differences in professional cultures related to length of time qualified and exposure to interprofessional and integrated working (section 2.8).

In the patient questions the decision was taken not to ask patients directly about Care Aims but about their experience of care although Care Aims is referred to in the accompanying information leaflet. It was considered that asking questions about Care Aims may introduce terminology that they were unfamiliar with and therefore negatively affect the response rate. It was decided to ask patients about their perception of team type and role and which members of the team they had come into contact with to enable triangulation with the responses from team members and managers. Patients were also asked about their expectations of care and whether the outcome had matched this: the literature review had identified that gaps in the literature included research based on the perception of patients rather than staff and limited evidence of outcomes for patients (Blundell, 2010).

Both the patient and staff questionnaires were preceded with an information leaflet (appendices 6 and 7) describing the aim and objectives of the study and also providing contact details for the researcher and university.

Other design considerations to facilitate a good response rate were meetings with the service manager, team co-ordinator and team to discuss and explain the study and to gain their support. Also the team meeting would give an opportunity to explain and discuss the inclusion criteria for patients as team members would be giving patients the questionnaire to complete.

Although the evidence base relating to use of coloured paper is inconclusive (Oppenheim, 1992; McColl et al, 2001) it was decided to use yellow paper for the team questionnaires as it was considered that these would stand out from other paperwork

on a busy office desk. Use of black ink on a white or yellow background is considered to also give the best contrast making the questionnaire easier to read (McColl et al, 2001).

#### **4.6 Evaluation of Context**

In order to better understand the context, the case study teams were operating in and to also facilitate cross case comparison, two standardised assessment tools – the Team Climate Inventory (TCI) (Anderson and West, 1996) and the Organisational Cultural Assessment Instrument (OCAI) were used. The measures were selected to assess team climate and culture. Context (section 2.10) is defined as the situation in which something happens (MacMillan, 2016). Johns (2006) argues that context can influence research results both powerfully and subtly and that researchers frequently ignore this. Johns (2006) argues that failure to understand context is one of the causes of variation in research results between studies. Denison (1996) develops this idea further, recommending holistic description of context as part of the research design to enable comparison between studies.

Denison (1996) identified that both culture and climate “*attempt to describe the holistic nature of social contexts in organisations*” (p.626) and there is a significant volume of evidence to support this view (Glisson, 2007), hence the use of measures of culture and climate in this study. The literature review (sections 2.7) explores both concepts, and that whilst inter-related, culture and climate provide different contributions to understanding context. Team climate is defined as employee perceptions and opinions about their working environment (Scott et al, 2001) and can change often and rapidly or slowly, unlike culture which is fairly stable longer-term construct (Turnipseed, 2008).

There are many tools available to assess culture and climate. Mannion et al (2008) identified more than seventy tools and that the different measures often reflected the sector where they had been developed e.g. business. It was therefore important to select measures that had been applied and evaluated in UK healthcare settings. For the cultural assessment tool, a further consideration was whether to select a measure of cultural type or dimensions of culture. A measure of cultural type rather than dimensions of culture was chosen, as the literature review (section 2.7) had suggested that many of the studies exploring integrated team working often referred to different dimensions of culture such as leadership. Selecting a tool that would measure only one dimension was considered too limiting when the literature review had suggested that

many of the different dimensions of culture influenced integrated team working. Looking at only one dimension could potentially bias the results.

One of the few tools that has been used in healthcare organisations and which also measures cultural type is the Organizational Cultural Assessment Instrument (OCAI) (Mannion et al, 2008). The OCAI (appendix 8) is a psychometric tool developed by Cameron and Quinn (1999) and is based on the Competing Values Framework. Its purpose is to help organizations and/or teams identify their current and preferred culture. Culture is classified according to four types:

1. Clan - Teamwork, participation and consensus are valued; held together by tradition and loyalty, an 'extended family', commitment is high.
2. Adhocracy - Dynamic, entrepreneurial and creative place to work. Risk taking is the norm. Commitment to experimentation and innovation.
3. Market - Results orientated, task focused. Emphasis on winning. Reputation and success very important.
4. Hierarchy - Rules and procedures dominate. The focus is on stability and predictability, efficiency and smooth running (Cameron and Quinn, 1999).

Research has shown that the OCAI is considered reliable and valid (McLaughlin, 2006). The OCAI comprises of two sections each with six questions. Respondents are asked to divide 100 points across four possible answers for each question i.e. an ipsative scale is used. For those who are mathematically minded this is relatively straightforward but for some respondents this can be confusing and may distort the results. One of the advantages of using an ipsative scale is that it forces a choice as options are compared rather than a likert scale that asks respondents score one statement which should give better differentiation in ratings. Another advantage of the OCAI is that it is a relatively short questionnaire. Also no free text responses are required which may improve the response rate. However the numeracy skill required may counteract this.

The Team Climate Inventory (TCI) was developed by Anderson and West primarily as a team development tool (Anderson and West, 1996) but has been used in research studies as a measure of team climate (Gosling and Westbrook, 2002; Gibbon et al, 2002; Borril et al, 2000). There have also been studies exploring its validity in different countries and settings (Mathisen et al, 2004; Kivimaki et al, 1997). However in the development stages the TCI was piloted extensively in the NHS so the tool was felt appropriate for use in the context of this study. The TCI questionnaire is not included in

the appendices as it is copyrighted. The TCI consists of 44 questions which respondents rate using a likert scale of 1-5; 1 being to a very little extent and 5 being to a very great extent. Similar to the OCAI the TCI is not very time consuming and does not require any free text responses. Whilst respondents are assured of anonymity when they take part in the study, the TCI questionnaire does ask respondents for their name although the questionnaire does state this is optional. This may influence the response rate.

The TCI is analysed by feeding the data into a computerised programme specifically designed for this purpose. As part of the analysis the researcher is asked to identify for each team a comparison group for the team data to be mapped to. Part of the development of the TCI by Anderson and West included significant testing in the NHS (Anderson and West, 1996) and development of comparator data for a range of different types of services including social services teams, NHS management teams and psychiatry teams. For this study the comparator team selected was primary care health teams as these were felt to be the closest to the teams in the case studies.

Both the TCI and OCAI have been shown to be reliable and valid and used in healthcare settings (Anderson and West, 1998; Scott et al, 2003). There were also examples in the literature where the Competing Values Framework and Team Climate Inventory were used together in studies exploring culture in integrated teams (Bosch et al, 2008; Hann et al, 2007). However the OCAI and TCI were considered to be the most appropriate assessments of culture and climate for this research.

The literature review (section 2.5) identified influential role of leadership in integrated team working and delivery of integrated care. Similarly Pettigrew et al (1992) identified leadership, the quality of managerial-professional relations and the quality and coherence of policy as factors which created a receptive context for change. Schein (2010) develops this further asserting that culture is "*ultimately created, embedded, evolved and ultimately manipulated by leaders*" (p.3). The perspectives of senior managers within the organisation were therefore considered important in order to more fully understand the context in which the case study teams were operating.

#### **4.7 Rigour**

A perceived weakness of case study research when compared to other social research methods is that it is considered as potentially lacking rigour (Rowley, 2002; Yin, 2014).

To address this concern, Lincoln and Guba (1985) proposed four criteria to assess rigour:

- Credibility – value and believability of the findings
- Dependability – concept of reliability, stability of the data
- Transferability – can the findings be transferred to another similar context or situation and preserve the inferences from the original study
- Confirmability – neutrality and accuracy of the data.

In this study a range of strategies were used to promote rigour. Primarily, the triangulation and integration of multiple sources of data helped to strengthen credibility and confirmability of the case studies. Credibility of the analysis and interpretation of the case study findings was also strengthened as the supervisory panel undertook a review of the proposed themes: member checking having been rejected as it was considered this would breach participants' confidentiality and anonymity. Additionally, this study adopted a systematic and replicable approach to data analysis (as described by Attride-Stirling, 2001) to strengthen dependability and confirmability. To increase transferability, this study contains detailed description and analysis of the context within which the case studies were carried out. Throughout this thesis, there is a clear audit trail of the decisions made and the rationale for this. Also included are reflections on these design decisions with the aim of increasing the neutrality and confirmability of this study.

#### **4.8 Potential Sources of Bias**

Social desirability is recognised as a common source of bias in experimental and survey research findings (Nederhof, 2006). This is where respondents will respond in a way that places them in a more favourable way with the researcher (Nederhof, 2006). It is possible that as a manager in the same organisation as the teams in the case studies, my role may have impacted on respondents in this way. Steps taken to mitigate this risk included questionnaires being given out and use of internal mail for return, emphasis on data collection being anonymous, use of written questionnaires rather than just interviews alone and the inclusion criteria for teams not directly managed by myself. Teams approached and selected for inclusion for the study came from another network/directorate. By asking both team members and patients to self-select for interview may introduce bias in terms of respondents 'having something to say'. However interview responses were triangulated with questionnaire responses which enabled exploration of data for supporting and disconfirming data. Team

members were also asked to complete the TCI and OCAI after the Care Aims questionnaires and interviews as it was felt the questions in the TCI and OCAI had the potential to bias results due to the nature of the questions they asked.

The TCI specifically includes a measure for social desirability which was triangulated with other responses from the case study.

The majority of patient respondents were likely to be elderly due to the type of services the teams provided. Visser et al (1989) reviewed the literature relating to social desirability and identified that it was more likely with elderly respondents but that this could be reduced by use of written questionnaires or if patients were questioned at home. In this study patients were offered written questionnaires to complete although these were given out by team members and although anonymity was explained on the patient information sheet, respondents may not have trusted this. This may particularly have been the case if they were still under the care of the team. By asking clinicians to select patients to give questionnaires to this may lead to bias in terms of clinicians selecting patients whom they feel may give a positive response. As I did not know at this stage if a patient had started their episode of care after Care Aims had been implemented I would not know which patients would meet the inclusion criteria. Patients were provided with a sealed envelope to return their response in so the clinician would not know what responses the patient had given or whether they have returned a blank questionnaire.

There was also potential for researcher bias particularly as this was a qualitative study in my employing organisation. As a researcher I was aware of this potential bias and frequently reviewed and reflected on the decisions made especially during the analysis stage to mitigate this effect. Guidance and input from the supervisory team who were independent of the NHS organisation was also a critical part this process.

#### **4.9 Summary of Research Design**

One of the criticisms of case study research is that measures are not well developed and subjective judgements are used instead (Yin, 2014). In order to enhance construct validity Yin (2014) recommends using multiple sources of evidence, establishing chains of evidence and having key informants review the draft case study report. Table 4.2 (p.67) and figures 4.1 (p.68) and 4.2 (p.70) demonstrate the use of multiple sources of evidence used in this study. Key informants were not asked to review the draft case

study report as it was considered this would breach the confidentiality and anonymity that respondents were assured of in the information leaflets. The draft case study findings were reviewed by the supervisory panel.

Table 4.2 Data sources

| <b>Data Source</b>      | <b>Patient</b>                                 | <b>Team Member</b>                | <b>Senior Manager</b> |
|-------------------------|--|-----------------------------------|-----------------------|
| Care Aims questionnaire | ✓  | ✓                                 | x                     |
| Interview               | ✓  | ✓                                 | ✓                     |
| OCAI                    | x  | ✓                                 | ✓                     |
| TCI                     | x  | ✓                                 | x                     |
| Documentary evidence    | ✓<br>e.g. patient information on Trust website | ✓<br>e.g. team triage information | x                     |

#### **4.10 Method**

This section describes how data was collected. Following a team having been identified as completed Care Aims training, a meeting was arranged with the service manager to discuss the study and to explore with the manager whether they were agreeable to the team taking part. The support of the manager was considered crucial to a good response rate. If the manager was agreeable then the team coordinator was contacted to discuss the study and to explore whether the team met the inclusion criteria. If the team met the inclusion criteria and the team coordinator was agreeable to the team taking part in the study then I arranged to attend a team meeting. At the team meeting the aim and objectives of the study and an outline of the method were presented to the team. If the team were agreeable to taking part in the study the questionnaires about the team and Care Aims were distributed. The patient questionnaires were also left for team members to distribute to patients who met the inclusion criteria. This first stage of the process is summarised in figure 4.1 (p.68).

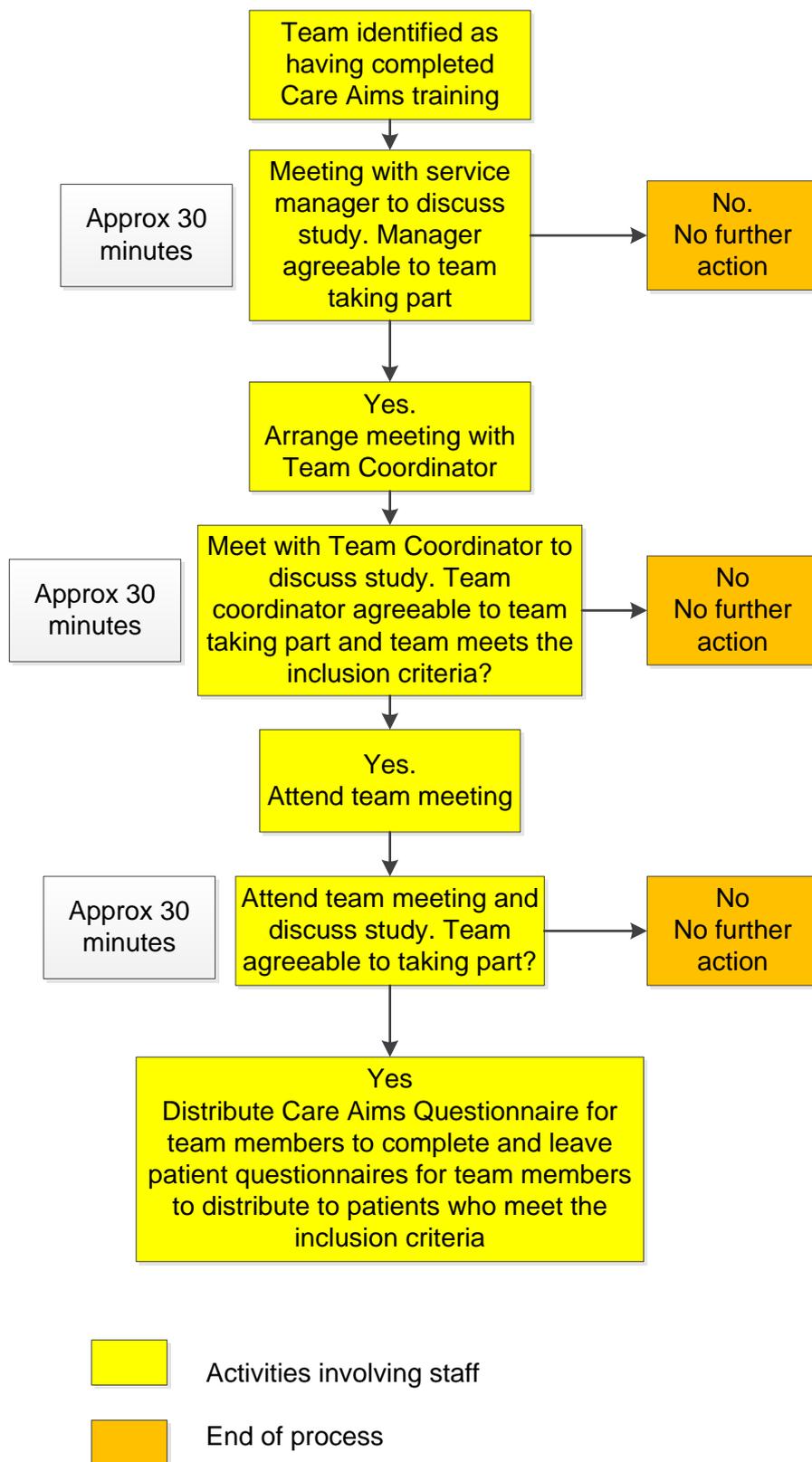


Figure 4.1 – Method for team and patient data collection – part 1

Two to four weeks after the initial team meeting the OCAI and TCI were distributed to team members at a team meeting. All questionnaires were to be returned via the

internal organisational post: this incurred no cost to the individual, was easily accessible and facilitated anonymity. If the response rate two weeks after the OCAI and TCI was distributed was less than 50%, a reminder was sent to team members via the team coordinator. If the response rate four weeks after the OCAI and TCI was distributed was less than 50%, a second reminder was sent to team members via the team coordinator.

If team members identified on their completed questionnaire that they were willing to participate in an interview, then they were contacted to arrange a mutually convenient time and venue to do this. At the interview, team members were asked to read and complete a consent form. Interviews were recorded and then transcribed verbatim. Interviews lasted no longer than 60 minutes and followed a similar format to the questionnaires that asked about the team and Care Aims. The outline interview schedule is in appendix 3.

Patient questionnaires included a sealed envelope for the patient to return the questionnaire to the member of staff in, for the member of staff to return in the internal organizational post. Similar to the team member questionnaires, the patient questionnaire asked patients if they would be willing to participate in an interview. If patients were then this would be arranged at a mutually convenient time and venue. Similar to the team member interviews, patients were asked to read and complete a consent form; interviews were recorded and transcribed verbatim. Interviews were also anticipated to last no longer than 60 minutes.

The second part of the method is summarised in figure 4.2 (p.70).

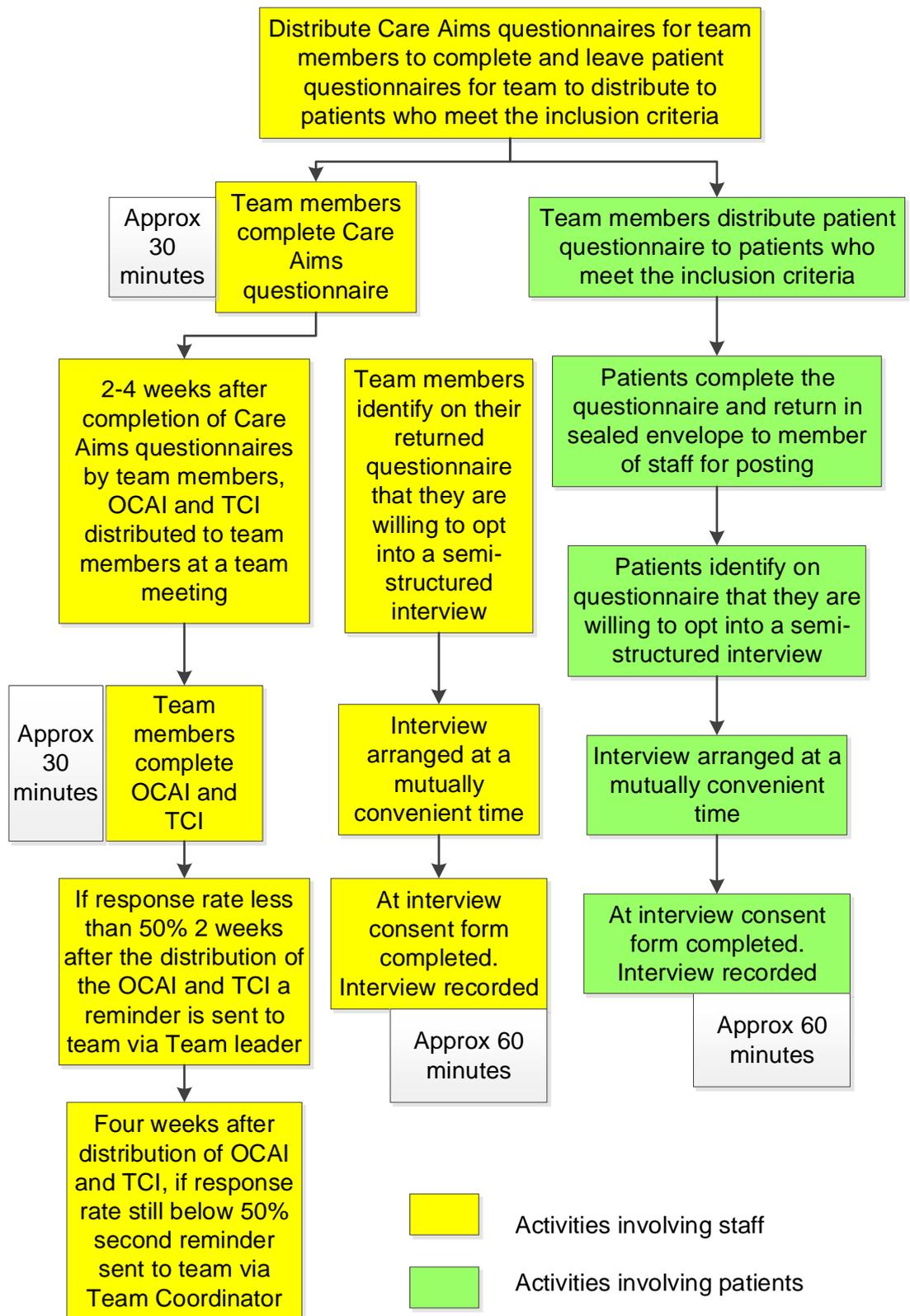


Figure 4.2 – Method for team and patient data collection part 2

#### **4.11 Ethical and Organisational Research Approval**

Ethical and organisational research approval was also sought and gained from:

- NHS via Integrated Research Application System (IRAS) – Ref: 11/NW/0082
- University of Central Lancashire – Ref: CA number 188
- NHS Primary Care Trust – no reference number
- NHS Foundation Trust – Ref: 11/25

#### **4.12 Pilot Study**

The method was piloted prior to the larger study commencing. This was to identify any potential sources of ambiguity, confusion or other difficulties with the methods of data collection and analysis (Walliman, 2016). In the pilot study the team coordinator distributed the OCAI and TCI. As the response rate for these questionnaires was much lower than the team Care Aims questionnaires the process was changed so that the researcher distributed the OCAI and TCI at a team meeting. This led to an improved response rate in case study A.

The team Care Aims questionnaire remained unchanged as following the initial analysis of the questionnaire data it was felt to be satisfactory. Team members were also asked to feedback any comments or improvement suggestions about the questionnaires. None were received.

During the pilot study it was not possible to recruit patients due to the inclusion criteria. The decision was therefore made to proceed with the patient questionnaire unchanged.

As the design of the study remained virtually unchanged, it was decided to include the pilot data in the main study. The data from the pilot case study is therefore reported as case study 1 in chapter 6 and referred to as case study 1 in subsequent chapters.

#### **4.13 Data Analysis – Phase 1**

Earlier in this chapter whilst describing the Critical Incident Technique, analysis of data was briefly described. Team Care Aims questionnaires, patient questionnaires and all interview data was analysed using the process described by Attride-Stirling (2001) to

develop thematic networks. Thematic networks were developed for each of the individual case studies and to report the findings of the interviews with the managers.

One of the challenges for qualitative research is the ability to replicate and report transparently and systematically the process followed. The approach developed by Attride-Stirling (2001) describes a systematic approach for conducting thematic analysis of qualitative data.

A coding framework was first developed. As this was an exploratory study it was decided to devise the coding framework using recurrent issues in the text rather than pre-established criteria. The text from the team and patient questionnaires and interviews for each case study was dissected using the coding framework. It is important to ensure that the coding framework has explicit boundaries so that they are not interchangeable or superfluous (Attride-Stirling, 2001). Once all the text has been coded themes were then extracted from the coded text segments by re-reading the text and reframing it to enable identification of underlying patterns and structures. The themes were then refined so that they are specific enough to be discrete and broad enough to encompass the ideas in the text segments. Next the themes were arranged to form the basic themes. The basic themes were then grouped into larger, shared issues to form the organising themes. The organising themes were then analysed to deduce the global themes: the global theme summarising the main argument or concepts that the organising themes are about. Each global theme then produces a thematic network. The next step is to describe the contents, using the text segments to support the description. As the thematic networks are explored, underlying patterns will appear. Thematic networks are not the analysis but a tool in analysis (Attride-Stirling, 2001). The thematic networks are summarised diagrammatically to facilitate understanding (sections 5.7, 6.5.5, 6.6.5 and 6.7.6).

As described in section 4.6 the data from the TCI was processed using the TCI software provided with the questionnaires. The programme then generates a report for each team whose data is entered into the system. The report details the team's performance based on the TCI responses against 15 subscales all of which describe aspects of team climate (section 6.2).

The OCAI results were processed and analysed using the method described by Cameron and Quinn (1999). This led to the creation of the diagrams (section 5.4 and 6.3) which show the perceived dominance of four cultural types for a team as it is now and how team members would like it to look in the future.

#### **4.14 Data Analysis – Phase 2**

For phase 2, the cross case analysis, a different approach was used. Yin (2014) suggests the creation of word tables using different categories. The categories are identified by the researcher and enable comparison between the case studies. Yin (2014) suggested that the categories can either be pre-defined or not. In this study the categories were not pre-defined and were identified by reviewing the features of each case study on a case by case basis.

#### **4.15 Summary**

This chapter describes and provides justification for the method and methodology adopted for this exploratory study. In phase 1 of the study, a series of case studies were undertaken using questionnaires and interviews based on the Critical Incident Technique and documentary evidence to collect data. Two standardised assessment tools, the OCAI and TCI were used to collect supplementary information about culture and climate respectively. Interviews with managers also took place to provide additional contextual information. Thematic networks were used to analyse and present data. For phase 2 of the study cross case analysis was undertaken.

## **CHAPTER 5**

### **ORGANISATIONAL CONTEXT AND MANAGEMENT RESULTS FOR ALL FOUR CASE STUDIES**

#### **5.1 Introduction**

This chapter describes the organisational context at the time of the study by reporting and analysing the interview and OCAI responses from three managers. This chapter provides the background and contextual information to the organisation that all the case studies were from. The influence of organisational context is explored further in the cross case analysis in chapters 7 and 8.

#### **5.2 The Management Team**

The Management Team was the senior management team for the organisation at the time the decision was made to formally introduce Care Aims into the organisation.

The Management Team consisted of the equivalent of an Executive Director, Directorate Managers and Performance and Quality leads. The senior management team was accountable to the Provider Board. All the case study teams were part of the organisation led by this management team with the exception of case study 4. The team in case 4 were initially managed by a different organisation but at the time of the study were part of the new larger organisation created as a result of the merger.

Approximately three years after the initial introduction of Care Aims into the organisation, the organisation, along with three others, was merged with a much larger organisation. As a result the most senior management team changed but all the managers interviewed for this study retained senior posts within the new organisation.

Within the new organisation Care Aims continued to be rolled out to new teams, one of which was case study 4. The management data was collected approximately three to four years after Care Aims was first introduced to the organisation but at a similar time to when data collection for case studies 1, 2 and 3 took place. Data collection for case study 4 was completed approximately 12 months later.

### 5.3 Team Climate Measure

At the time of data collection the original management team was no longer in place and had been replaced by the management team in the newly formed organisation. This informed the decision not to ask the senior management team to complete the Team Climate Inventory as it was felt it would be difficult for the managers to complete retrospectively due to the number of detailed questions and many of the managers from the original management team were no longer working in the new organisation. Also the TCI would be specific to their team unlike the OCAI which would reflect more the organisational perspective.

### 5.4 Team Culture Measure

It was decided to ask those members of the original management team who agreed to be interviewed to complete the Organisational Cultural Assessment Instrument. As the OCAI is much shorter than the TCI and the questions are less specific it was felt that those interviewed would be able to complete this retrospectively.

Two managers completed the OCAI. The 'now' culture refers to the perceived culture in the organisation at the time Care Aims started to be implemented. Both managers perceived that the dominant culture at the time was a market culture (figure 5.1, p.75) with the second dominant cultures being different: adhocracy for manager 1 and hierarchy for manager 3.

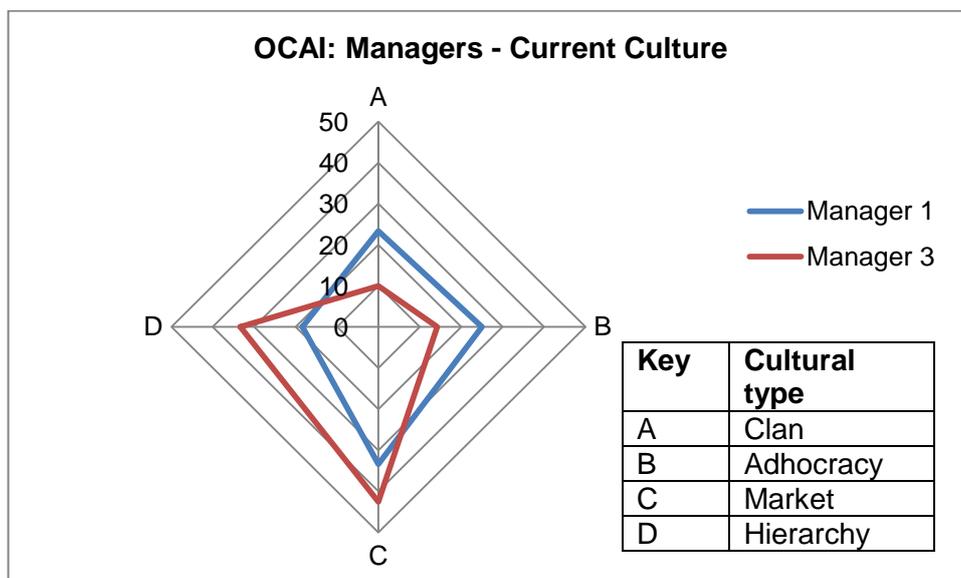


Figure 5.1 OCAI results showing the managers' perception of the current culture

The OCAI suggested that both managers would prefer a different culture from the market culture they perceived was the dominant culture. Both managers preferred dominant culture was clan and second preferred culture was adhocracy (figure 5.2, p.76).

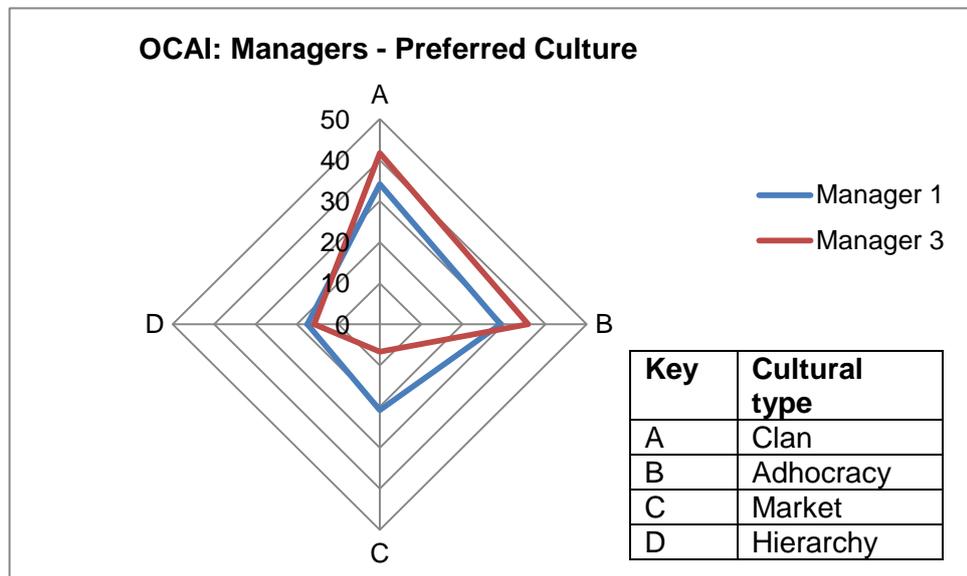


Figure 5.2 OCAI results showing Managers' identified preferred cultural type

### 5.5 Manager Interviews

All of the three managers approached agreed to be interviewed. Since Care Aims implementation and merger with the new organisation, many of the original managers were employed elsewhere limiting the number of available managers. All of the managers interviewed were members of the senior management team at that time. All had clinical backgrounds although none had practised as clinicians for some time. Each was from a different clinical profession and these included an allied health professional and a nurse.

### 5.6 Results from the Interviews with Managers

This section reports the interviews with the managers, exploring understanding of Care Aims, introduction of Care Aims to the organisation and the subsequent implementation.

### 5.6.1 Understanding of Care Aims

Each of the managers had different perceptions of Care Aims ranging from a:

*“model which supports clinical reasoning and evidencing the decision making within practice”* (Manager 1, page 2, line 12)

to

*“clinicians and professionals look at the way they work, look at their working practices, look at best practice out there and then implement that”* (Manager 2, page 1, line 14)

to a framework to:

*“improve patient care” with several strands* (Manager 3, page 1, line 11).

All were agreed that Care Aims would support clinical decision making.

### 5.6.2 Introducing Care Aims

Manager 1 led and was responsible for the introduction of Care Aims to the organisation and suggested to the senior management team that Care Aims would be a beneficial approach to use. Manager 1 described a personal experience that led to a search for a model where clinicians could clearly articulate their clinical reasoning and communicate more clearly their decisions to others. This manager met managers from other organisations who were using Care Aims and was impressed by their experience which included improving the effectiveness of conversations with service users and other partners. Manager 1 described that at the time they were:

*“personally convinced it was the way to go”* (Manager 1, page 3, line 13).

Managers 2 and 3 gave a different perspective. Both referred to the financial challenges the organisation faced, reducing waiting times, more efficient services and the need to enthuse clinicians.

*“I had a really good conversation about how we had to improve our efficiency and do things and reduce waiting times and things like that”* (Manager 2, page 3, line 13).

All referred to the need to change the emphasis in the organisation to focus more on quality.

### **5.6.3 Implementing Care Aims**

Manager 1 gave several specific examples of how Care Aims had influenced and empowered clinicians. The examples included responding to a complaint and responding to a proposed change in service specification. Managers 2 and 3 gave less specific examples and described in more general terms the changes they had seen. Examples included reduction in waiting times, achieving a performance target by delivering a care pathway differently, enthusiastic staff and a reduction in open duties of care.

Both managers 2 and 3 also suggested that in the future a slightly different approach may be required for a range of reasons including the appropriateness of the approach for all services.

### **5.7 Resulting Thematic Network for Manager Interviews**

Similar to the case studies the data were analysed using the approach described by Attride-Stirling (2001). Interview data was coded and then further dissected into coded text segments. These were then grouped and interpreted as basic themes. Seventeen basic themes were then clustered and five organising themes identified. The five organising themes were then summarised as two global themes (table 5.1, p.79).

Table 5.1 Themes generated from management team interviews

| Basic theme                        | Organising theme                  | Global theme                    |
|------------------------------------|-----------------------------------|---------------------------------|
| 1. Financial challenges            | 1. Driving forces for change      | 1. Receptive context for change |
| 2. Personal success                |                                   |                                 |
| 3. Clinician's voice               |                                   |                                 |
| 4. Clinicians leading change       |                                   |                                 |
| 5. Waiting times                   |                                   |                                 |
| 6. Need for cultural change        |                                   |                                 |
| 7. Adapting Care Aims              | 2. Showing emotional intelligence | 2. Outcomes                     |
| 8. Showing empathy                 |                                   |                                 |
| 9. Sustaining change               |                                   |                                 |
| 10. Understanding Care Aims        | 3. Challenges of Care Aims        |                                 |
| 11. Alternative models             |                                   |                                 |
| 12. Different interpretations      |                                   |                                 |
| 13. Limitations of Care Aims       |                                   |                                 |
| 14. Manager/clinician relationship | 4. Less tangible outcomes         |                                 |
| 15. Changing culture               |                                   |                                 |
| 16. Improved performance           | 5. Tangible outcomes              |                                 |
| 17. Clinician morale               |                                   |                                 |

The thematic network for each of the global themes is presented in turn (sections 5.7.1 and 5.7.2).

### 5.7.1 Theme 1: Receptive Context for Change

The first theme is a receptive context for change with figure 5.3 (p.80) detailing the thematic network for this theme. Similarities with significant aspects (Newton et al, 2003) of the receptive contexts for change model developed by Pettigrew et al (1992) can be seen e.g. effective managerial – professional relationships, simplicity and clarity of goals and priorities, supportive organisational culture, availability of key people leading the change.

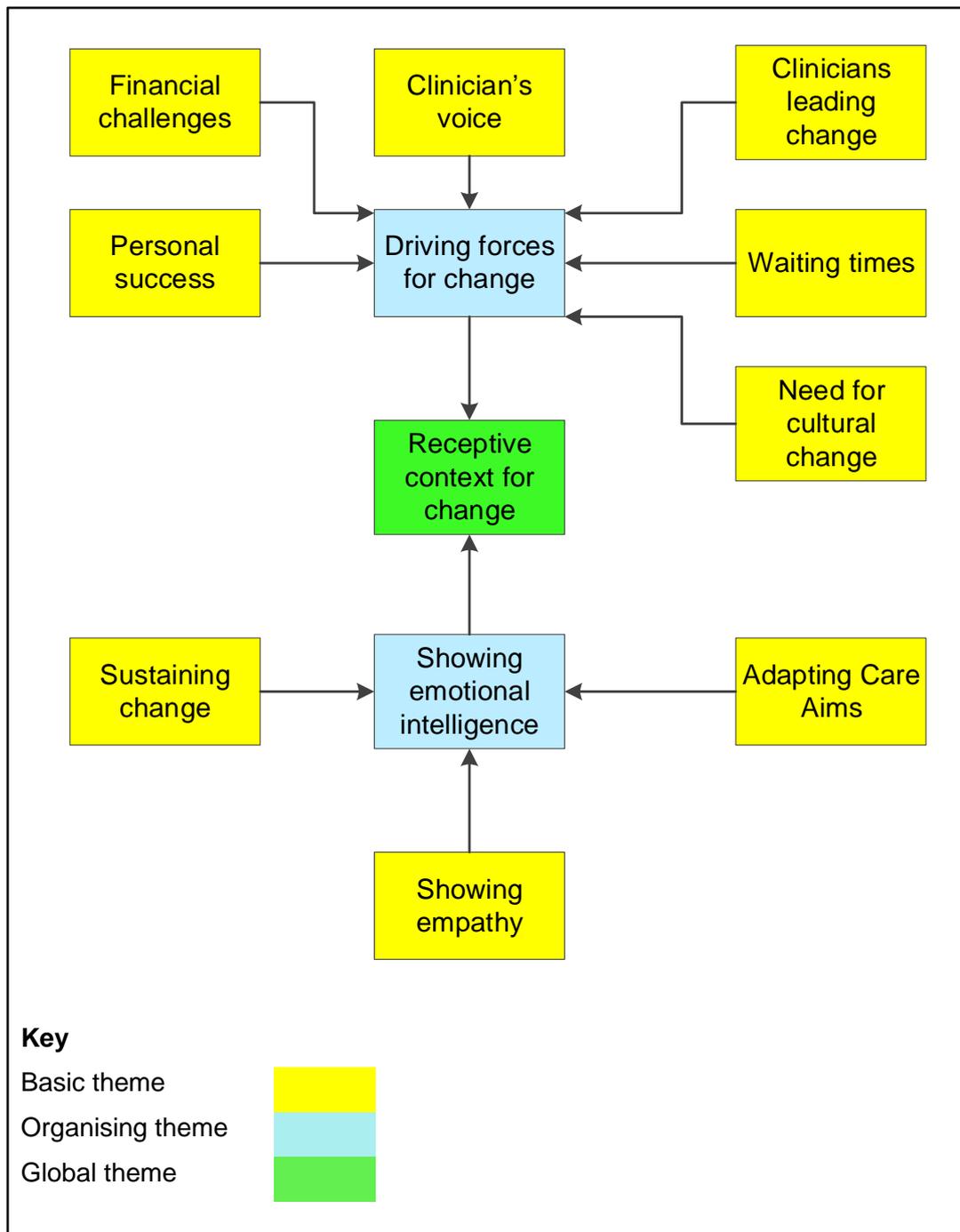


Figure 5.3 Thematic network for a receptive context for change

The first organising theme is driving forces for change. All the managers were able to clearly describe the drivers for the organisation introducing Care Aims. All three expressed a need for wanting clinicians to be able to articulate their decisions but as a result of different experiences. Manager 1 described wanting to be able to strengthen clinical reasoning and for clinician's to be articulate their decision making. This was based on the manager's personal experience supporting clinical staff through a tribunal type process which the service had lost.

For managers 2 and 3 the challenging financial situation the organisation was in was a critical driver for change. Supporting their perception of the current strong market culture, Manager 2 described the current financial deficit and worsening annual position. Manager 3 described the need to demonstrate value for money and:

*“if I can be blunt, to take some money out of the system”* (page 3, line 10) (basic theme 1, table 5.1, p.79).

Waiting times and a need to improve efficiency was also a driver. Manager 2 describes being:

*“under real pressure to improve access times”* (page 4, line 6) (basic theme 5, table 5.1, p.79).

There was a desire to empower clinicians to lead change. Manager 1 described this in the context of services moving into a business management model where clinicians could influence and drive change and better support the business manager to make decisions. Manager 2 described this is in the context of needing to improve relations with staff after a period of significant change and learning from that experience. This is consistent with a preference for a dominant clan culture. Manager 3 described the change in the context of senior managers needing clinicians to lead change after finding themselves in a position where:

*“there were areas of work that clearly either we shouldn’t be doing or someone else should be doing and we weren’t really empowered to make some of those difficult decisions”* (page 2, line 26) (basic theme 4, table 5.1, p.79).

All three managers described wanting the culture to change so that there was a greater focus on quality although the extent of this varied. For Manager 1 it was about trying to move away from the current dominant market culture: *“trying to shift away from the activity/input focus”* (page 3, line 22) (basic theme 6, table 5.1, p.79).

Whereas Managers 2 and 3 appeared to be concerned with getting a better balance of quality and effectiveness with efficiency and cost. This could be perceived as supportive of a stronger adhocracy culture in the future where innovation and being the service leader are important. Manager 3 said that as a management team they were looking for something they could:

*“proactively and positively sell to services as something they could really use to become more efficient and provide better services to patients”* (page 3, line 4) (basic theme 6, table 5.1, p.79).

The OCAI results also appear to support the wish to change the culture from a dominant market culture to a preferred dominant clan culture.

Two of the managers described their personal need for this change to work. Manager 1 described regret at not being able to put forward an alternative case and that the outcome of the formal process may have been different. For Manager 3 the need for success was different:

*“I quite personally felt that if we didn’t get on top of some of these things then, not my role, but some of my, yes, my role would be undermined”* (page 4, line 8) (basic theme 2, table 5.1, p.79).

The managers appeared to show emotional intelligence. They showed empathy for clinical staff and other stakeholders. Manager 2 said:

*“almost exclusively people were very positive, some people were very scared, there was anxiety, there was a lot of anxiety”* (page 3, line 18) (basic theme 8, table 5.1, p.79).

Manager 1 described staff frustration at wanting to influence management and commissioning decisions and the time taken for processes to be worked through. Manager 3 described having to base some decisions on trust and trusting colleagues in the senior leadership team:

*“trusting the people who were selling the vision”* (page 2, line 20) (basic theme 7, table 5.1, p.79).

There was recognition by the senior management team that for the change to be sustained clinicians needed to lead the change. Manager 2 said:

*“if the service leads this then it’s also got a chance of being much more effective”* (page 3, line 16) (basic theme 7, table 5.1, p.79).

It was also identified that teams needed to adapt Care Aims to embed it. Manager 1 said:

*“I think the services that have adopted the philosophy and model have done so in ways that they have personalised for themselves”* (page 3, line 25) (basic theme 9, table 5.1, p.79).

Many of the factors that create a receptive context for change as described by Pettigrew et al (1992) including key people leading the change and effective managerial clinical relations. In Schein’s conceptual model for managed change (2010)

the management team had sufficient disconfirming data and connection to that to cause discomfort and create motivation to change i.e. unfreeze the system. Consistent with this is Weiner's concept of organisational readiness (2009). In addition to their individual reasons for supporting the change the managers valued the change enough to commit to its implementation and be confident they could do so despite of the apparent different outcomes they thought introducing Care Aims could achieve.

### **5.7.2 Theme 2: Outcomes**

The second thematic network is for the global theme 'outcomes' (figure 5.4, p.84). The organising themes draw together different aspects of the outcomes: organising theme 1 relates to the challenges of Care Aims; organising theme 2 the less tangible outcomes and organising theme 3 the tangible outcomes. The range of outcomes is apparent.

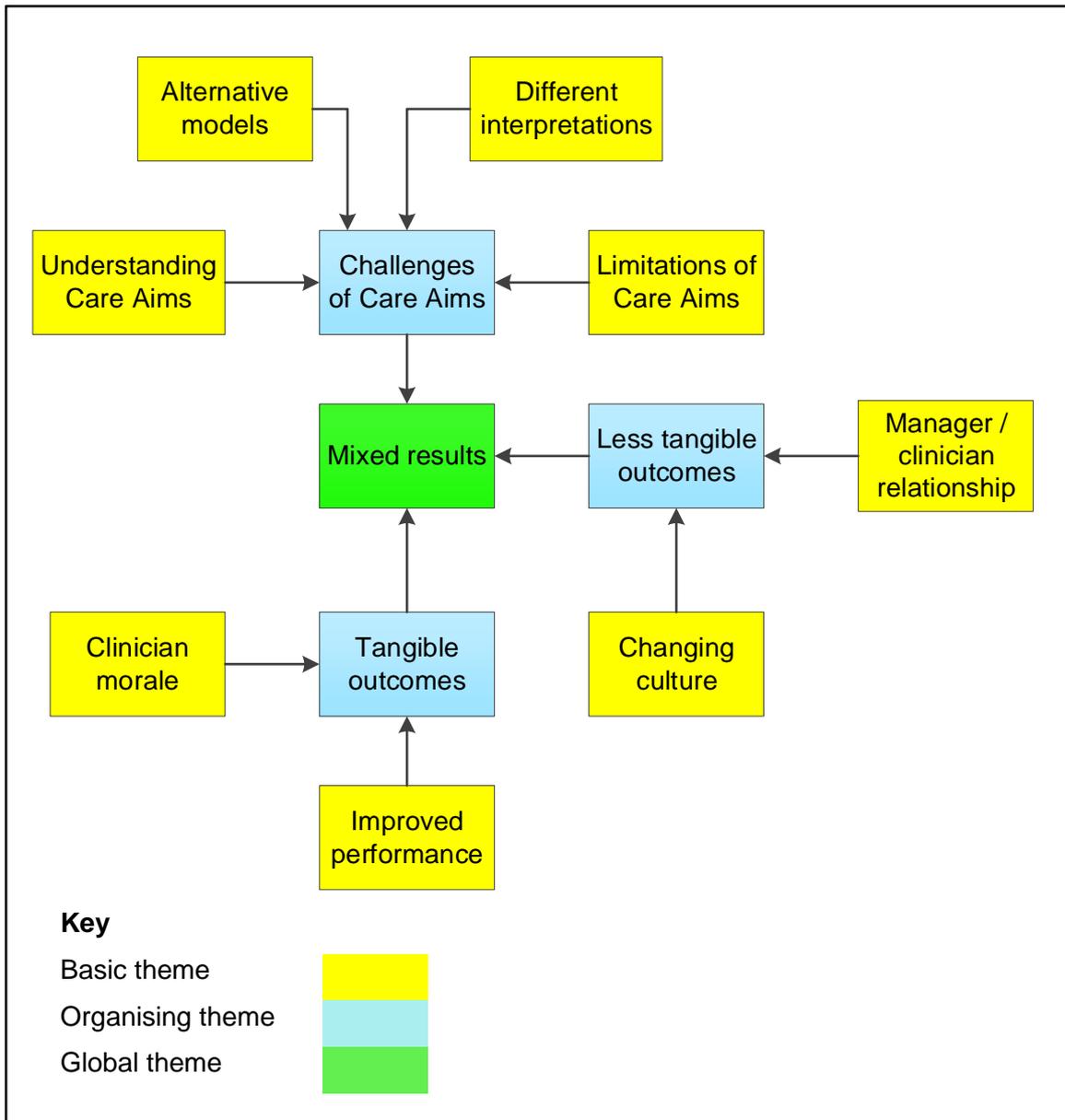


Figure 5.4 Thematic network for outcomes

The managers appeared to have different understandings and perceptions of Care Aims (section 5.6.1). It is possible their cultural preference influenced their understanding of Care Aims. For example Manager 1 had a strong preference for clan which is also about facilitating and coaching to gain improvement. Manager 1 perceived Care Aims as a supportive model for frontline staff. This may have influenced their expectations of the outcomes implementing Care Aims could achieve. It would appear that there was an inconsistent vision of the outcomes from implementing Care Aims and this appears to be reflected in the different understanding of Care Aims the managers disclosed. This may explain why two of the three managers felt that going forward a different model was required. Manager 2 felt a hybrid approach was required because:

*“there’s something Care Aims misses because if you don’t focus on efficiency in cash terms as well then you miss opportunities to deliver cash releasing benefits”* (p. 8, line 12) (basic theme 11, table 5.1, p.79).

Manager 2 felt a different model was needed but for different reasons. Manager 2 felt that Care Aims was not all relevant to all services. Manager 2 also felt that Care Aims was quite difficult to understand and that perhaps there could be:

*“simpler, I don’t know annotated way of doing it that isn’t necessarily purist kind of Care Aims. That is, another version of the truth”* (p.5, line 10) (basic theme 11, table 5.1, p.79).

There was recognition that Care Aims could be difficult to understand. Manager 1 felt that staff who had been qualified for longer found it harder to change their thinking. Manager 2 felt that Care Aims was very technical and felt some staff, particularly non-qualified staff would struggle with it.

Care Aims has its roots in Speech and Language Therapy and it may be that assumptions have been made in relation to its resonance with other professions. However the manager’s responses and their perception of the approach suggest that there may be discord with their professional values and beliefs. It is possible that implementation may have been more successful if Care Aims had been perceived as being more compatible with the values of the healthcare professionals expected to implement Care Aims (Shortell et al, 1998). It should be noted though that the manager leading the implementation was an AHP.

There was also discussion that Care Aims was a ‘therapy’ model of Care which may limit its use and that it would be more difficult to use outside the organisation:

*“there is still something about Care Aims language not necessarily being the language that others outside the organisation would particularly understand* (Manager 3, p.4, line 15) (basic theme 13, table 5.1, p.79).

Manager 2 felt the organisation had “shied away” from using Care Aims with doctors and psychologists but did not state why. The lack of engagement from psychologists seen in case study 3 may be reflective of this. It is possible that the perception of the medical profession and psychologists in terms of professional hierarchy had influenced

this as all three managers interviewed were from professions possibly perceived as lower in the hierarchy.

Some of the outcomes from implementing Care Aims included an improved performance, particularly in relation to waiting times and improved morale of clinicians. These outcomes would sit particularly with the market culture.

The improvement in waiting times was described by Manager 2 as: "*Phenomenal, phenomenal achievements*" (p.7, line 2) (basic theme 16, table 5.1, p.79).

Manager 3 was more measured:

*"we have saved money, reduced waiting times at the same time and I think we've got less complaints"* (p. 6, line 1) (basic theme 16, table 5.1, p.79).

It was felt staff morale had improved. Manager 2 said that:

*"whenever I went to talk to people they really appreciated it, the investment in them, the investment in the organisation monetarily and time to try and change things from the position of clinicians and managers leading that service"* (p.3, line 30) (basic theme 17, table 5.1, p.79).

Manager 3 was more reserved:

*"it would be a sweeping statement to say that it has but I do think there is a lot of added value in terms of how people feel about what they deliver"* (p. 6, line 6) (basic theme 17, table 5.1, p.79).

Other outcomes such as improved clinician/manager relationships and change in culture were felt to be less tangible. Manager 1 said:

*"those changes in thinking and how people feel, the type of language people are using is much more difficult to evidence and they're the subtle changes that you only hear in conversations"* (p. 5, line 12) (basic theme 15, table 5.1, p.79).

In terms of culture (basic theme 15, table 5.1, p.79) Manager 1 felt there was "*still a way to go*" whereas Manager 2 felt that Care Aims had enabled the organisation to "*do more of the right thing*" (p.5, line 29).

Reflecting on the Care Aims model the managers who were not AHPs felt that a different model was needed in the future. This may be due to outcomes required and the apparent differences articulated by the managers rather than the Care Aims approach itself. It is possible that the focus was on the change i.e. implementing Care Aims rather than the goal or outcome Care Aims implementation was expected to achieve.

## **5.8 Summary**

The managers all described a range of drivers for introducing and implementing Care Aims. These drivers created a positive context for Care Aims to be implemented with similarities to the receptive contexts for change described by Pettigrew et al (1992). This positive context was strengthened by the emotional intelligence shown by the managers before and during implementation.

Professional culture also appears to have influenced implementation and evaluation of outcomes. Shortell et al (1998) noted that for continuous quality improvement to be successful, compatibility with the values of healthcare professionals is important. Incompatibility with professional values may explain this.

Care Aims appears to have been targeted at nursing and allied health professions with the reasons for not focussing on medical and psychology professions unclear. Despite many changes in healthcare, medicine is still identified as the most established and dominant healthcare profession (Baxter and Brumfitt, 2008) and if the managers view themselves as less powerful than the medical profession this could limit them asserting their authority (Barrett et al 2005) and pursuing Care Aims implementation with staff groups perceived as more challenging.

Despite the positive context for change the outcomes from implementation varied. Implementation presented a range of challenges. The intended outcomes of improvements in performance and staff morale were achieved. Not all outcomes were tangible. Expectations may have been influenced by the manager's different perspectives of Care Aims and the lack of a consistent vision for the outcomes Care Aims implementation would achieve. This would appear to support the views of Fuda (2009) and Schein (2010) who both assert the need to focus on the goal and not the change, particularly if the goal is the achievement of cultural change and not something more specific. Perceived current and preferred organisational culture also appears to

have influenced managers need for change, understanding of Care Aims and expected outcomes.

## CHAPTER 6

### INDIVIDUAL CASE STUDY RESULTS

This chapter introduces the four case studies and reports the findings of each individual case study.

#### 6.1 Introduction

The teams in the following case studies were all part of the same NHS Trust in the north of England. The Trust covers a large geographic area which includes urban and rural areas and areas of very high and very low deprivation. The Trust was initially a specialist Trust which took its current form as a combined community and specialist trust following the publication of the white paper *Our Health, Our Care, Our Say* (DH, 2006). As a result of that paper, three PCT provider arms joined the specialist Trust to form the combined trust in 2011. The trust employs around 7,000 members of staff working across more than 400 sites and provides services from cradle to grave.

As described in chapter 5 three of the case studies originated from the same PCT provider arm. This is also the same PCT provider arm that I was employed in too. The team in case study 4 came from a different PCT provider arm. The teams in case studies 1, 2, and 3 all provide services across the same two geographic localities whereas case study 4 provides services across one locality in another area. The teams are of varying size (table 6.1, p.89) ranging from case studies 1 and 2 which are the smallest having eight team members to case study 4 which was the largest with 20 team members.

Table 6.1 Team size

|  | <b>Case study 1</b> | <b>Case study 2</b> | <b>Case study 3</b> | <b>Case study 4</b> |
|--|---------------------|---------------------|---------------------|---------------------|
| <b>Approx. number of staff in team (headcount)</b> | 8                   | 8                   | 18                  | 20                  |
| <b>Average number of referrals per month</b>       | 50                  | 100                 | 45-60               | 160                 |

All the teams provide different aspects of specialist community based services for adults and older people with primarily physical difficulties. The teams assess and treat a variety of conditions. The teams in case studies 1 and 2 work predominantly with

chronic conditions, in case 3 sub-acute conditions and in case study 4 with acute conditions. All the teams include AHPs, but not all include nurses. All of the teams included occupational therapists and physiotherapists and case study 3 also included speech and language therapists. There were no medical staff in any of the teams. The professional mix in each case study is shown in table 6.2 (p.90).

Table 6.2 Professions represented in each case study team

|   | <b>Case study 1</b> | <b>Case study 2</b> | <b>Case study 3</b> | <b>Case study 4</b> |
|---|---------------------|---------------------|---------------------|---------------------|
| <b>AHPs</b>   | √                   | √                   | √                   | √                   |
| <b>Nurses</b>   | √                   | √                   | x                   | √                   |
| <b>Psychologists</b>  | x                   | x                   | √                   | x                   |
| <b>Healthcare Support Workers/trainee assistant practitioners /assistant practitioners (HSCW)</b> | √                   | √                   | √                   | √                   |

The teams in the case studies had different leadership models. Case study 1 had two team leads – a nurse and AHP; case study 2 had one team leader who was an AHP; case study 3 had three team leads who were all AHPs and case study 4 had one team leader – an AHP. In case study 1, the team leaders each managed one site. In case study 3 the three team leaders jointly managed the whole team together.

All the teams had completed Care Aims training but at different times (table 6.3, p.90). Care Aims started in one of the Provider PCT arms prior to joining the new combined Trust where implementation continued. Over time Care Aims and the training evolved (section 3.2).

Table 6.3 Implementation of Care Aims

|                     | <b>Implementer stage</b> | <b>Date of data collection</b> | <b>Length of time from training to data collection</b> |
|---------------------|--------------------------|--------------------------------|--|
| <b>Case study 1</b> | Early                    | July - December 2011           | Approx 2-3 years                                       |
| <b>Case study 2</b> | Mid                      | January – June 2013            | Approx 3 years   |
| <b>Case study 3</b> | Early                    | April – June 2013              | Approx 3-4 years                                       |
| <b>Case study 4</b> | Late                     | July - December 2013           | Approx 1-2 years                                       |

## 6.2 Team Climate Results

In all the case studies the response rate for the Team Climate Inventory (TCI) was below the recommended response rate of 75% (Anderson and West, 1996). Therefore caution should be applied to the results. The response rates for each case study are shown in table 6.4 (p.91).

Table 6.4 TCI response rates

| Response rate | Case study 1 | Case study 2 | Case study 3 | Case study 4 |
|---------------|--------------|--------------|--------------|--------------|
| Number        | 2            | 5            | 5            | 1            |
| %             | 28.6         | 71           | 36           | 5            |

Team climate appeared to vary across the case studies. In Case Study 1 the results showed a generally positive team climate (figure 6.1, p.92) with the exception of the subscales for perceived value and sharedness. These two areas are narrated in the TCI report for this team as:

*“team members perceive only some value and worth in the team’s objectives for themselves/the organisation/ wider society” (p.4)*

and

*“Some, but not all, team objectives are shared and agreed upon by team members” (p.4).*

The other area with a mid-scale score is attainability with the TCI report noting:

*“some team members feel objectives are attainable in practice but others feel that some objectives may be more attainable than others” (p.4).*

All other subscales are described as aspects where climate “*appears sound*” (p.6). However the social desirability response is high suggesting a falsely positive team rating i.e. there are likely to be inaccuracies in the reported social desirability scores portraying the team too favourably.

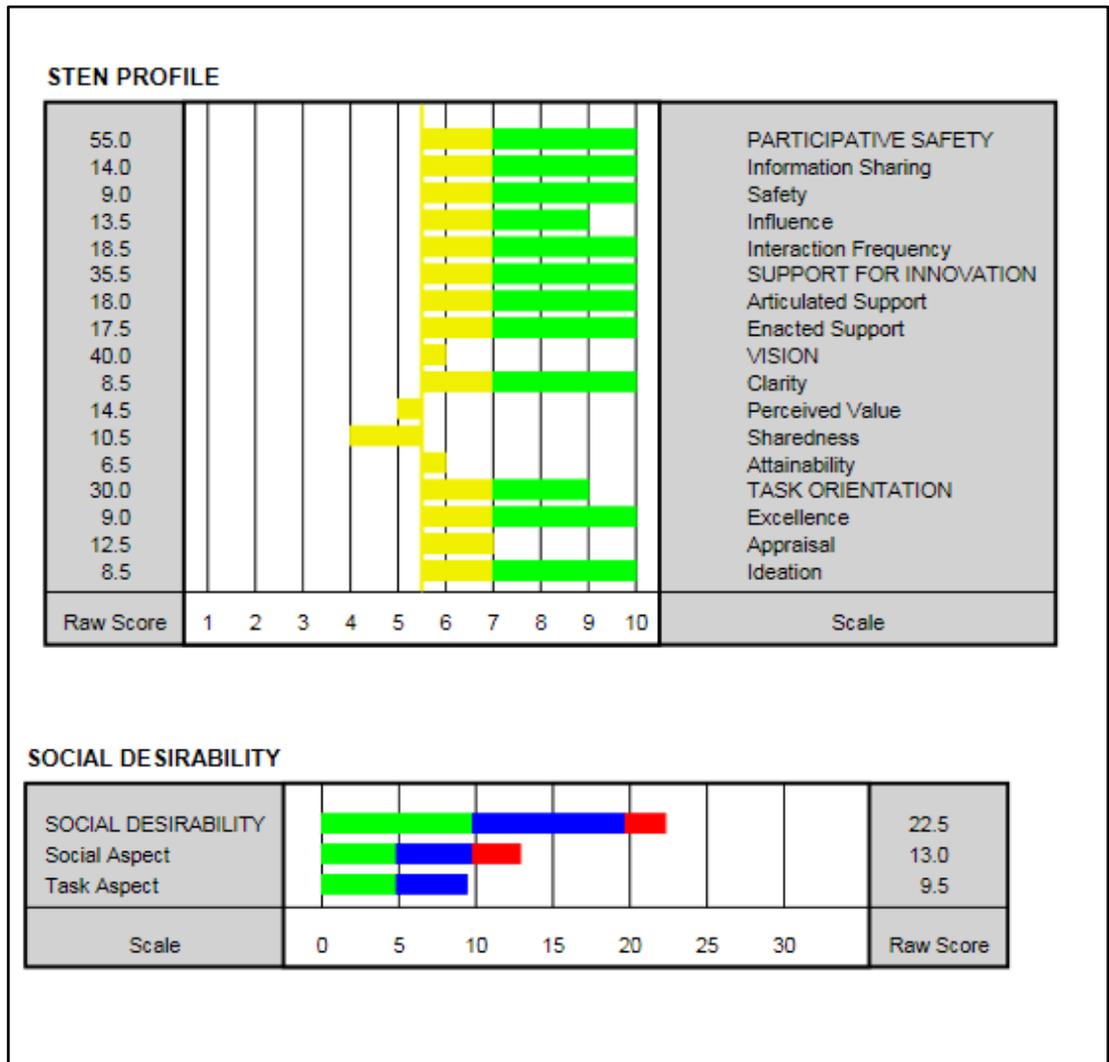


Figure 6.1 Case study 1: TCI results summary

In case study 2 the results showed an extremely positive team climate (25.2), more so than in case study 1 (figure 6.1, p.92). Similar to case study 1 the exception was the subscale for attainability (figure 6.2, p.93).

Again similar to case study 1 in the TCI report for case study 2 all other subscales are described as aspects where climate “*appears sound*” (case study 2 TCI report, p.6). However the social desirability response of 25.2 is very high, much higher than in case study 1, suggesting a falsely positive team rating i.e. in reality too positive to be likely.

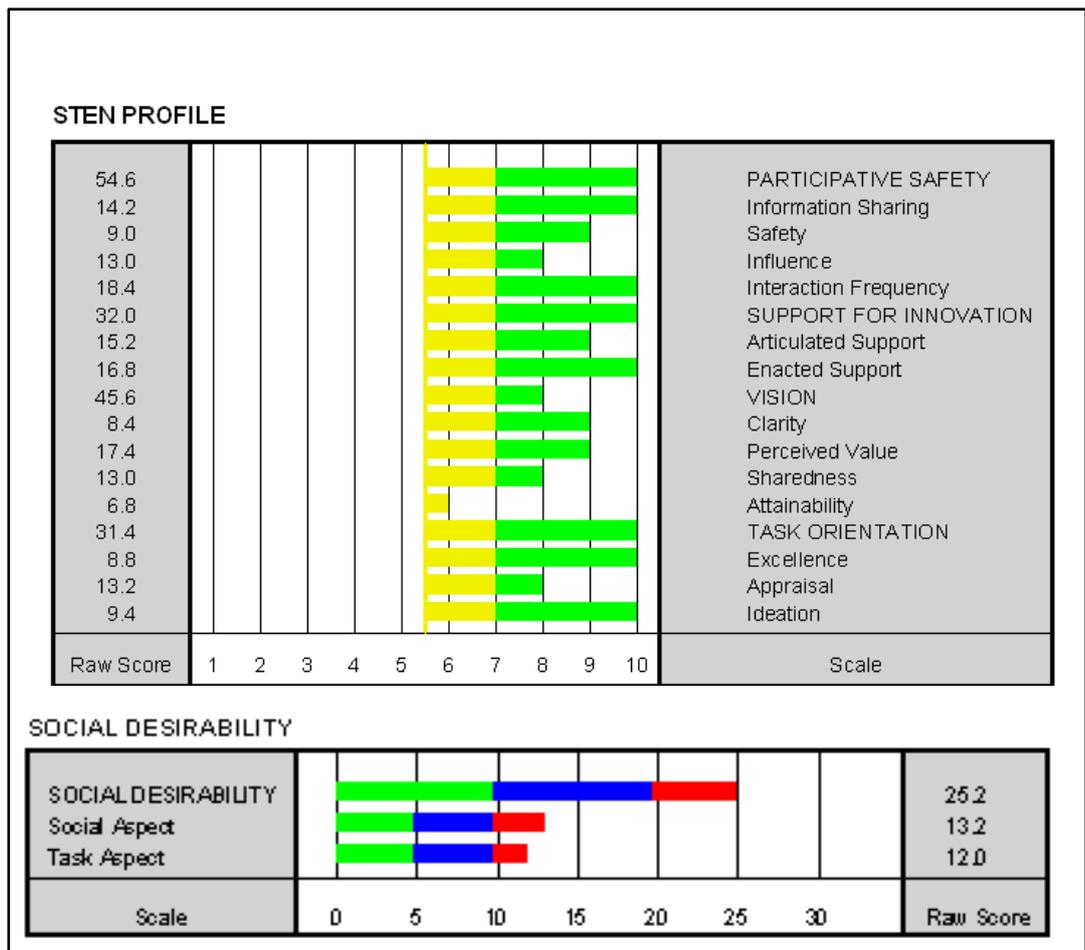


Figure 6.2 Case study 2: Team Climate Inventory results

Whilst there were similarities between the team climates in case studies 1 and 2, case study 3 reported a very different team climate. More areas (figure 6.3, p.94) were identified as requiring development as the results were far less positive. Whilst information was considered to be shared regularly, levels of trust between team members varied. The team was reported to meet regularly. The team said they were supportive of innovation and were supported to develop new ideas and they found time for developing new and improved ways of doing things.

Not all team members were clear about all of the team’s objectives and not all objectives were agreed by all team members. Team members reported they perceived only some value in the team’s objectives. The team was committed to providing high quality services but did not always identify weaknesses in the team or monitor the quality of team member’s work.

Similar to case studies 1 and 2 the TCI report identified that there may be some inaccuracies over the reported social climate for social aspect but likely to be

inaccuracies over the social climate for task aspect. However this was less so than in case studies 1 and 2 suggesting perhaps a more 'honest' report of team climate by team members.

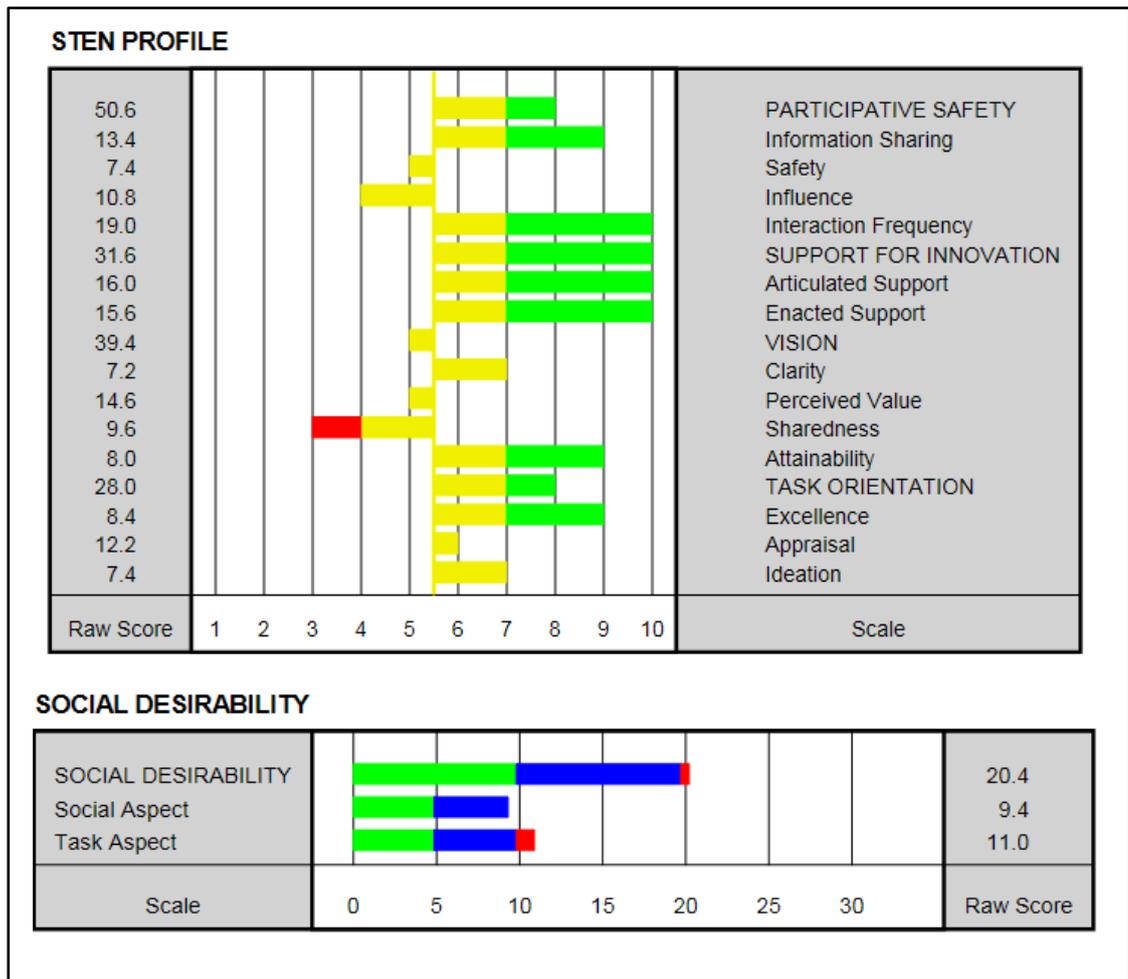


Figure 6.3 Case study 3: TCI results

For case study 4 only one TCI response was received. Therefore the data from the Team Climate Inventory (TCI) could not be analysed using the software provided as more than one response is required. Therefore the data from the TCI has been descriptively analysed. Caution should be applied as this is the perspective of one individual and analysed outside the prescribed framework. The majority of questions were answered with a positive response (agree or strongly agree) with the exception of the following:

- Assistance in developing new ideas is readily available – disagree
- People in the team never feel tense with each other - neither agree or disagree

The answers to the questions about the team's objectives were also answered positively. All scored 3 or 4; 3 being somewhat and 5 being completely.

### **6.3 Team Culture Results**

As the OCAI was administered with the TCI the number of questionnaires returned is identical to the TCI results in all cases with the exception of case study 3 where four OCAI questionnaires were returned rather than five (table 6.4, p.91). Descriptors of each cultural type are in section 4.6.

In case study 1 respondents perceived different dominant cultures within the team: clan and market. It is not known whether both respondents are based at the same site or different sites. However both would prefer the dominant culture to be a clan culture with a strong second culture being that of hierarchy (figure 6.4, p.96). The preference for a more dominant clan culture (figure 6.4, p.96) would appear to be consistent with the social desirability score in the TCI suggesting that the team may not be functioning as well as they wish to portray. This may be related to the team being located across two sites.

Similar to case study 1, the team in case study 2 had different perceptions of the dominant culture at the time they completed the OCAI (figure 6.5, p.97) with most respondents identifying a preference for the dominant culture to be clan (figure 6.5, p.97). The results suggest that members of the team perceive there were two dominant cultures within the team: clan and hierarchy. The responses suggested that the team aspired to a clan cultural type with the hierarchy cultural type the second dominant preference. This appears to indicate a desire for a culture within the team that is more team focussed with improved team working and consensus.

In case study 3 team members report different perceptions of the dominant culture at the time they completed the OCAI (figure 6.6, p.97). Two of the five questionnaires were completed with tick boxes rather than a numerical value. In these instances the tick was interpreted as 100% and a box left blank interpreted as 0%. There appears to be little consistency between team members regarding the current dominant culture with perceptions that the clan, hierarchy and market cultures are all the dominant culture. However three of the four respondents would prefer the dominant culture to be clan which would appear to resonate with the TCI results regarding the team's objectives and social desirability. Two of the team would prefer a much stronger

adhocracy culture which does not appear to be consistent with the TCI results for innovation.

In case study 4 the current dominant culture is perceived to be market (figure 6.7, p.98). The preferred culture is adhocracy closely followed by clan. Market culture is least dominant in the preferred culture. The current market culture may be directly related to the type of clinical specialty the team provide which is about providing urgent care to avoid hospital admission and facilitate early discharge where the team's response will be expected to be time sensitive.

A comparison of the current and preferred cultural type for each team is shown below.

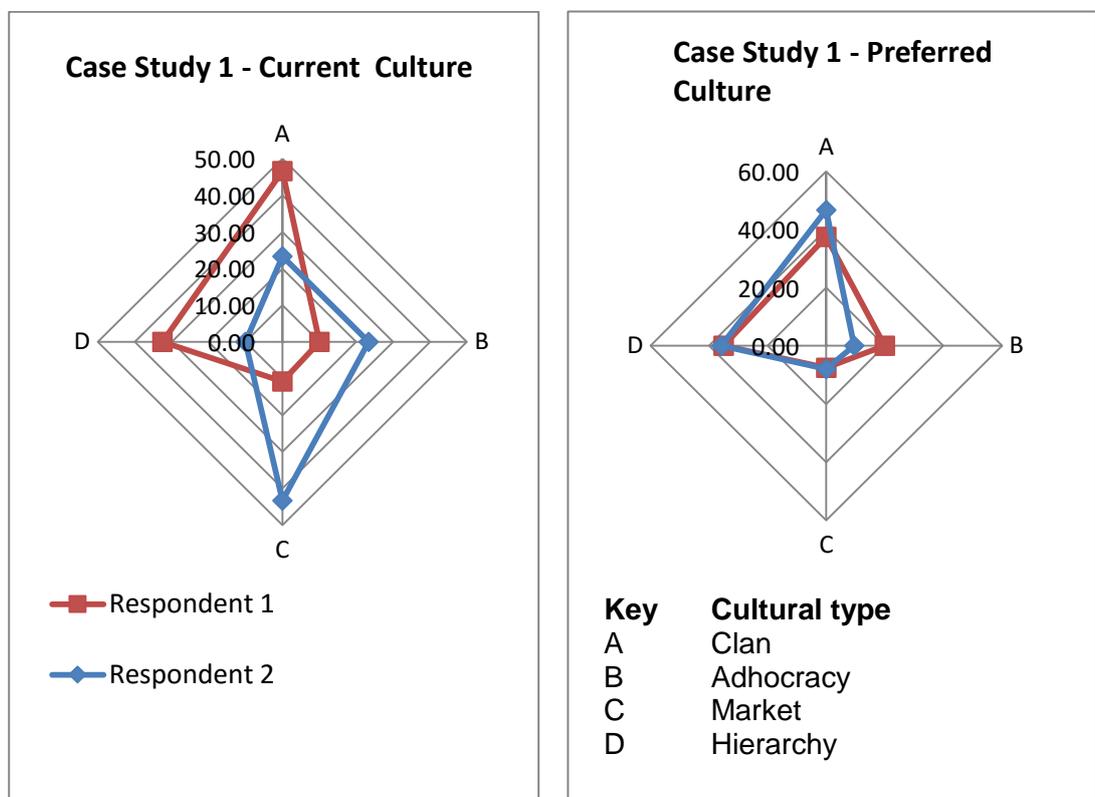


Figure 6.4 OCAI results for case study 1

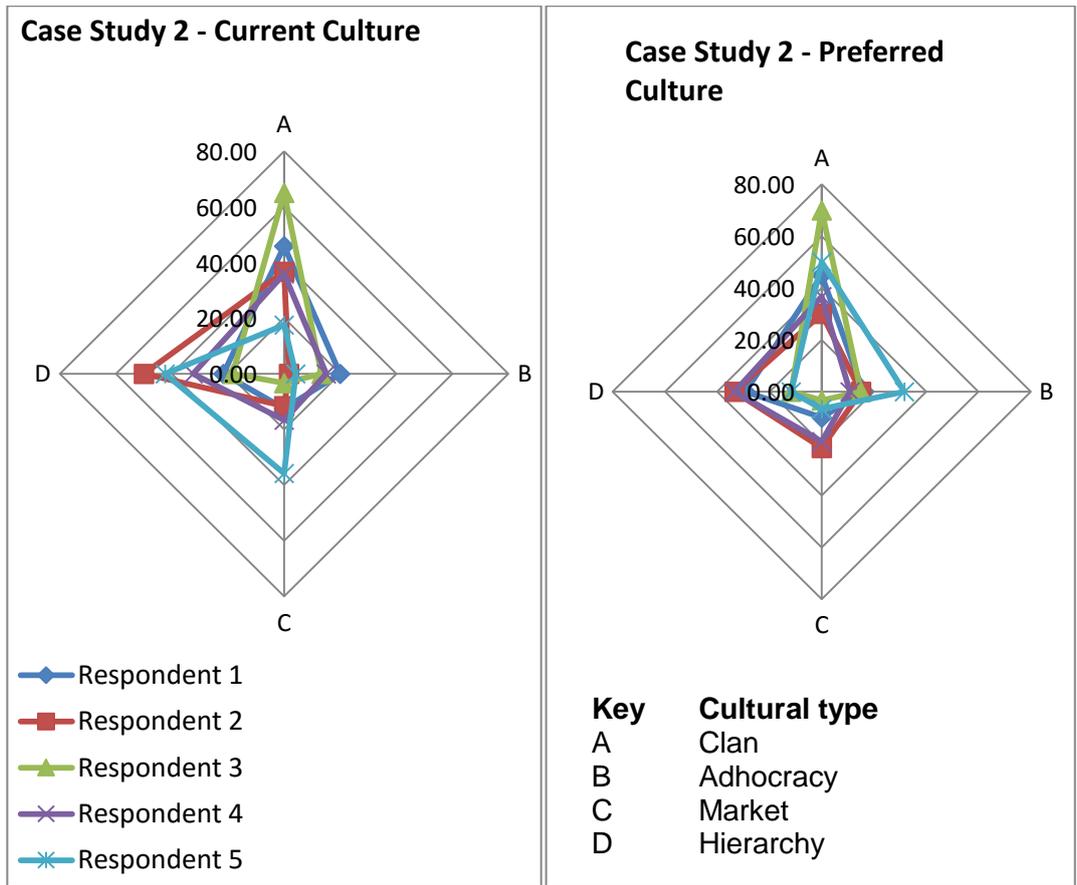


Figure 6.5 OCAI results for case study 2

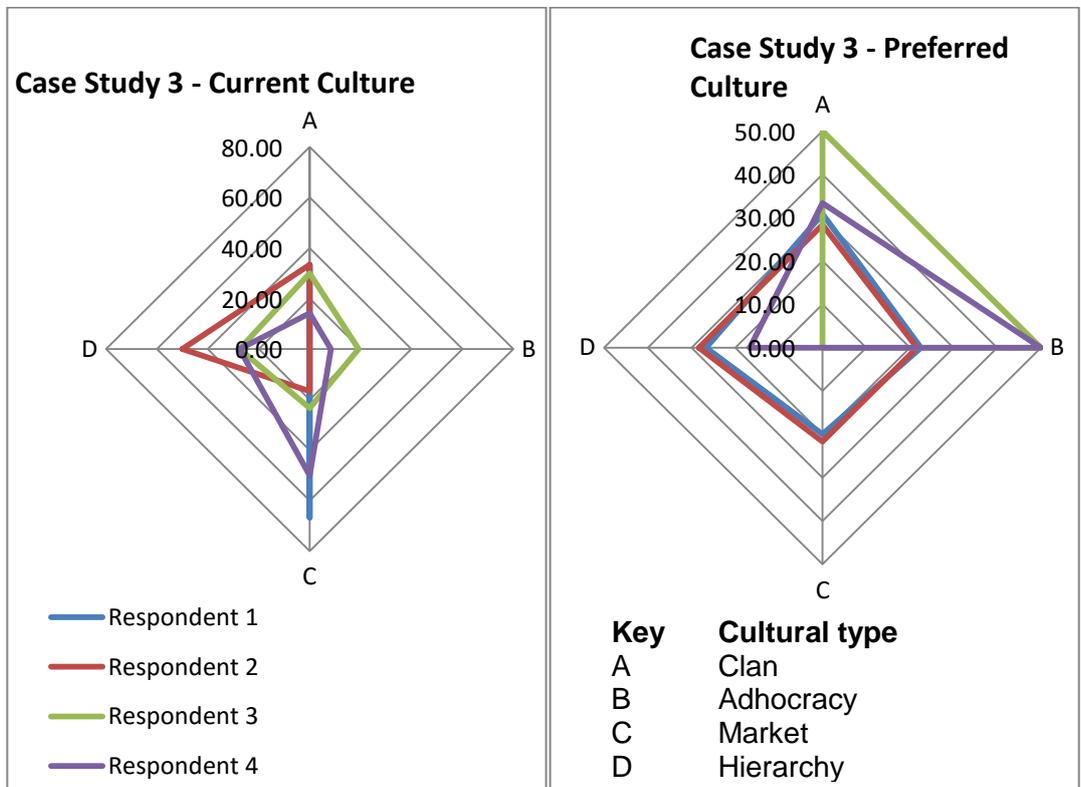


Figure 6.6 OCAI results for case study 3

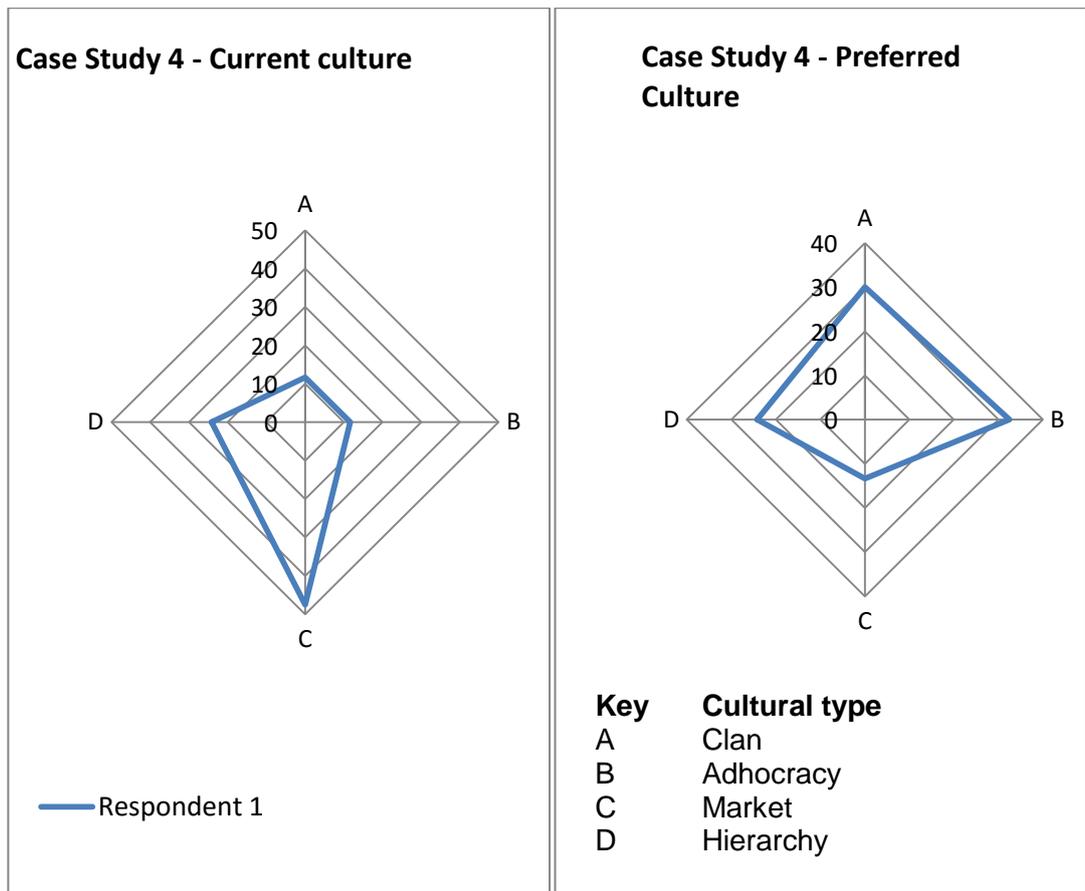


Figure 6.7 OCAI results for case study 4

It can be seen that while none of the case studies or the managers have a shared view of the current cultural type in their team. There appears to be more consistency between team members in each case study regarding their preferred cultural type.

#### 6.4 Summary of the Introduction to the Case Studies

Although the case studies share some similar features, there is considerable variation between the case studies in terms of team composition, care aims experience, climate and culture. However there are some themes that appear to emerge:

- Case studies 1 and 2 report high social desirability scores. These are also the teams that include both nurses and AHPs.
- Case study 3 has the lowest social desirability score of the case studies and the highest number of team leaders
- All the case studies perceived there was more than one dominant culture present in their team. The more members a team had, the higher the number of

dominant cultures perceived to be present in a team. This did not appear to relate to response rate. This was also similar for the number of team leaders: the team with the most team leaders also had the greatest diversity for current and preferred dominant cultural type

- The smaller teams (case studies 1 and 2) had greater consistency for their preferred cultural type than the larger teams (case study 3).
- There appeared to be no relationship between Care Aims implementation and culture and climate.
- The teams with the highest social desirability scores had the greatest preference for a dominant clan culture.

## 6.5 CASE STUDY 1

Section 6.5 presents and analyses the findings for Case study 1. This is the case study which was the pilot study.

### 6.5.1 Response Rates

The response rates for the questionnaire and interviews are shown in table 6.5 (p.100).

Table 6.5 Case study 1: Response rates

| <b>Method of data collection</b>         | <b>Number completed</b> | <b>Response rate</b> |
|--|-------------------------|----------------------|
| Team Care Aims questionnaire             | 5/7                     | 71.4%                |
| Semi-structured interview – team members | 2/7                     | 28.5%                |
| Patient Care Aims questionnaire          | 0                       | N/A                  |
| Semi-structured interview – patients     | 0                       | N/A                  |

Five team members (71%) responded to the questionnaires and two of the team also participated in semi-structured interviews. Questionnaire responses were representative of the professions and grades of staff within the team. A nurse (Nurse 1) and AHP (AHP 1) took part in the interviews.

### 6.5.2 Results from Team Care Aims Questionnaire

#### **Respondents**

All the respondents were female and included both AHP and nurses. Whilst the team included both occupational therapy and physiotherapy staff only one AHP responded. Staff grades ranged from bands 3-7. Four of the respondents had worked in the team for more than 2 years and one had worked in the team between 6 months to one year. Their ages ranged from 24 to 50 years.

#### **Perception of team type, role and function**

With the exception of AHP 1 who described the team as multi-professional, the team described themselves as multi-disciplinary. When asked to describe their role in the team AHP 1 identified that the team provided specialist assessments relating to their

profession whilst the other respondents were more general in their response and did not refer to their profession in relation to the assessment and treatment they provided. Terminology used to describe the patient in the questionnaire responses varied – AHP 1 tended to use the term client more than the term patient whereas all the nursing respondents mainly used the term patient.

### **Implementing and using Care Aims**

Care Aims appeared to have impacted team members in similar ways. When asked to describe how Care Aims was introduced to the team, all recalled the ‘formal’ training days but differed in their accounts of the events that followed. This did not appear to relate to profession or band. Responses included looking at goal setting, an audit of referrals, changing the referral form and using the ‘Admission/treatment indicators profile’.

When asked to describe an incident or event that happened when they were implementing Care Aims, all but Healthcare Support Worker 1 (HCSW 1) reported that the Care Aims model had enabled them to manage their caseload better by giving them ‘permission’ to discharge patients and close their duty of care in cases where previously they would not have done. This was reported as having helped manage caseload sizes, to step back and not duplicate on care. This was consistent across AHP and nursing respondents. When asked to describe a time when they had used the Care Aims approach, all respondents to the question gave examples related to process e.g. looking at referrals, discharging patients.

All but HCSW 1 who had yet to complete the training, used words such as individual approach, positive outcome, setting goals and outcomes, impact on patient whereas the examples were about opening a duty of care and discharging patients. This was consistent for both AHP and nursing team members. All the responses gave examples in relation to the respondents’ own profession with no examples demonstrating an integrated approach to care assessment or planning. All the nursing respondents expressed fears that clients/patients could fall between services because of referral criteria.

### 6.5.3 Results from Team Care Aims Interviews

#### The interviews

The interviewees had already completed the team Care Aims questionnaire. Both interviewees were graded band 7 and had worked in the team for more than 2 years. One was an AHP (AHP 1) and one was a nurse (Nurse 1) and at the time of interview working from different bases from each other.

#### Perception of team type, role and function

Similar to the questionnaire responses the AHP described the team as multi-professional whereas the Nurse 1 described the team as multi-disciplinary. AHP 1 described how the team had initially started as a nursing continence team but when the opportunity had arisen several years previously the nurse lead had decided to restructure the team to reflect national guidance that was promoting multi-professional working. Initially this was a pilot to see whether there were benefits for service users and gradually over time posts were substantiated and hours for the AHPs increased. Responses to role of the team were similar to the questionnaire responses.

When interviewed Nurse 1 and AHP 1 described different approaches to care. AHP 1 felt that AHPs were more enabling, expecting patients to participate in their care compared to nurses who were more caring. This was reinforced by Nurse 1 who said:

*“it wasn't reciprocal you know if it was very much, the stance was almost we can provide we can improve your health and if you comply with us and this is what we're going to do x, y and z”* (Nurse 1, p. 2, line 16).

Questionnaire responses from the nurses in the team included:

Nurse 1 - having a *“misplaced sense of responsibility for patients”* (Team Questionnaire 1, question 8); expressing surprise that patients can *“take responsibility for their own healthcare – we can trust them”* (Team questionnaire 1, question 11);

Nurse 2 – *“some referrals seem to fall through the gaps between services referral criteria”* (Team questionnaire 2).

Nurse 3 - *“a worry that something that you think is being covered by another service has not been”* (Team Questionnaire 7, question 12)

#### Implementing and using Care Aims

AHP 1 described Care Aims as a way of managing demands on the service and delivering services to those patients that they are most likely to effect change. Nurse 1

had a similar response describing Care Aims as being about managing the work done with patients as being as effective as possible for both patients and staff but also went on to describe the governance benefits of Care Aims; defining roles and responsibilities for both patients and staff, being safe as a practitioner, knowing when to stop providing care.

Both interviews reflected on the personal impact of the Care Aims training with AHP 1 describing “*personal unpicking*” (AHP 1, p.3, line 26) but both were positive about using Care Aims in the future, AHP 1 being “*excited*” (AHP 1, p.5, line 22) and Nurse 1 saying training was “*liberating*” (Nurse 1, p.2, line 21). Both acknowledged the challenge that lay ahead of them to fully implement Care Aims.

Both AHP 1 and Nurse 1 gave examples of how they had used Care Aims. AHP 1’s examples were about processes and tasks e.g. managing and accepting referrals and being able to discharge patients. Nurse 1’s examples were more about her role as a nurse e.g. reflecting on whether she was effectively managing a patient and being clear about her role in a patient’s care, allowing patients to make decisions and being comfortable with accepting those decisions. This suggested that Care Aims training had impacted differently on them.

AHP 1 gave several examples describing conversations with referrers who appeared not to understand the role of their service and not to welcome the challenge to why they were referring, which AHP 1 described as frustrating several times during the interview.

AHP 1 was able to describe several specific scenarios (anonymised) but this appeared to be more challenging for Nurse 1 who preferred to give more generic responses even when asked several times to give specific examples.

#### **6.5.4 Results from Patient Care Aims Questionnaires and Interviews**

##### **Response rate**

Unfortunately there were no responses to the patient Care Aims questionnaire. This also meant that there were no responses to the patient interviews as the questionnaire was used to recruit patients to be interviewed.

### **6.5.5 Developing the Thematic Network**

The thematic networks were developed following the process described in section 4.12. From the data, codes were further dissected into coded text segments; 120 coded text segments were identified and these were then grouped and interpreted as basic themes. The 19 basic themes were then clustered and seven organising themes identified. The seven organising themes were then summarised into three global themes (Table 6.6, p.105).

Table 6.6 Themes generated from case study 1

| Basic theme  | Organising theme                                | Global theme                 |
|--|---|------------------------------|
| 1. Ineffective clinical caution                                | 1. Wanting change                               | 1. Change management process |
| 2. Patients' best interests                                    |   |                              |
| 3. Historical paternalism                                      |   |                              |
| 4. Frustration and dissatisfaction                             |   |                              |
| 5. Using Care Aims inappropriately                             | 2. Learner anxiety                              | 2. Professional cultures     |
| 6. Anxieties about implementing Care Aims                      |   |                              |
| 7. Care Aims as the solution                                   |   |                              |
| 8. External team relationships                                 | 3. Differing levels of change                   |                              |
| 9. Recognising team working barriers                           |   |                              |
| 10. Enabling therapists  | 4. Challenging traditional values and practices |                              |
| 11. Challenging personal and professional beliefs              |   |                              |
| 12. Professional cultural awareness                            | 5. Acting differently                           |                              |
| 13. Autonomy   |   |                              |
| 14. Changing traditional practice and beliefs                  | 6. Enabling patient empowerment                 |                              |
| 15. Empowering patients  |   |                              |
| 16. A patient-centred approach                                 | 7. Enabling role clarity                        |                              |
| 17. Involving other professionals                              |   |                              |
| 18. Not feeling respected                                      |   |                              |
| 19. Clarifying team role and responsibilities and welcome this |   |                              |

### 6.5.6 Theme 1 – Change Management Process

The resulting thematic network for the first theme of change management process is shown in figure 6.8 (p.106). Similarities with the first stage of the managed change process described by Schein (2010) can be seen. The organising themes describing two aspects of the unfreezing stage when motivation to change is created.

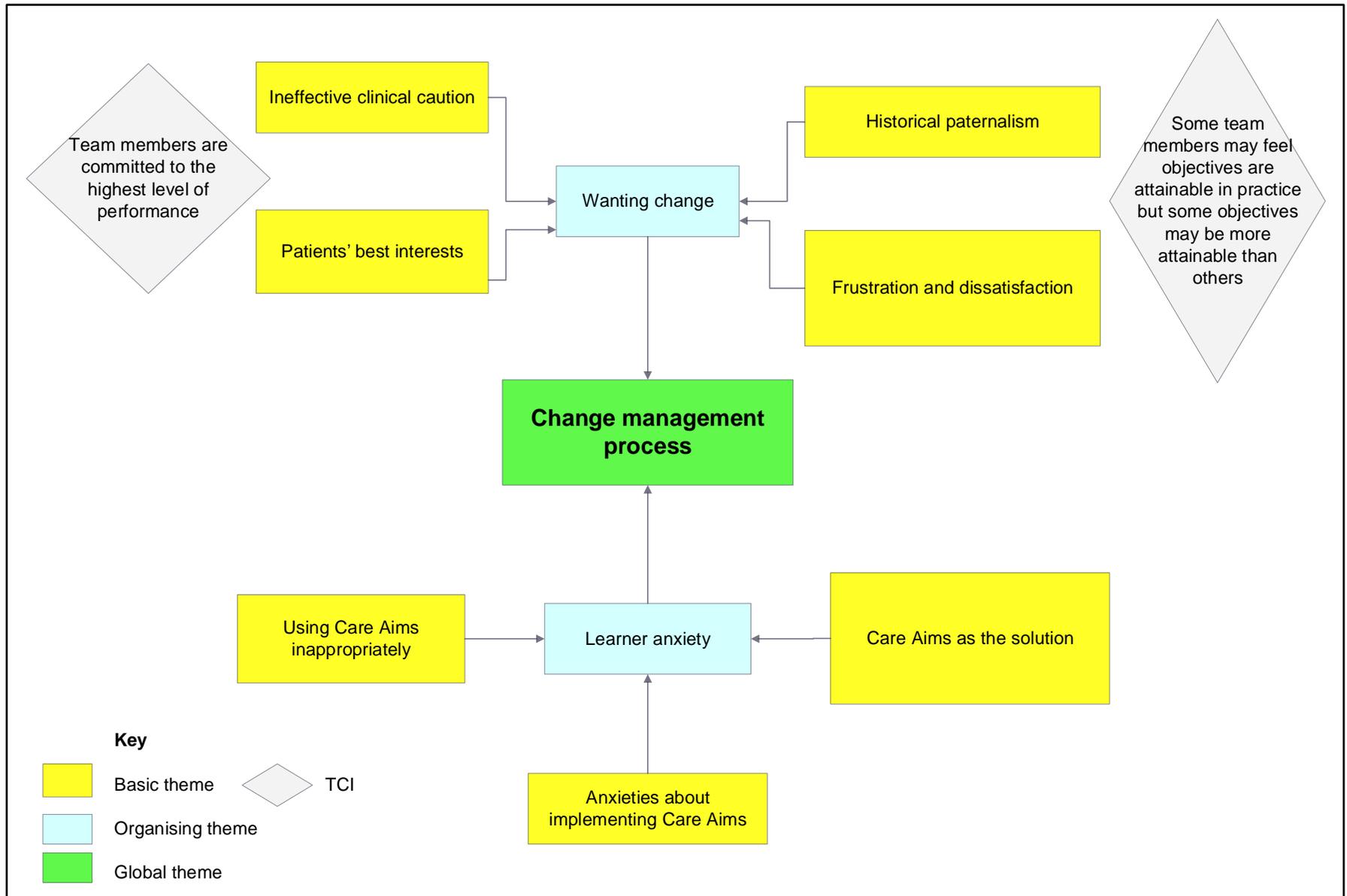


Figure 6.8 Case study 1: Theme 1 - Change management process

As can be seen in figure 6.8 (p.106) the change management process appeared to be as important as the change itself. This is supported in the literature where various change implementation models are described (Armenakis and Bedeian, 1999; Barnard and Stoll, 2010; Schein, 2010; Kotter, 1995; Iles and Sutherland, 2001) although Fuda (2009) argues against thinking change can be managed and that there are 'X' steps to change are both flawed assumptions.

The team expressed dissatisfaction with their current ways of working and volume of work and a desire for the current state to change. There was a recognition that the traditional paternalistic attitude they held towards patients was not in the best interests of the patient and at times decisions by professionals had been made not for the benefit of patients. The team appeared to view Care Aims as an approach that would improve care for people. For example Nurse 1 said:

*"there'll inevitably be one or two cases stick in your mind that you got wrong and you think hell, you know the guilt, clinician's guilt floods in"* (Nurse 1, p.6, line 15) (basic theme 1, table 6.5, p.100)

and

*"it's a dangerous way to practice and I hadn't appreciated that"* (Nurse 1, p.6, line 9) (basic theme 1, table 6.6, p.105).

The team wanted to maintain fidelity to the Care Aims approach but felt they were still learning and had anxieties about the model particularly expressing concerns about patients either falling between services or the staff member missing something. The team described how they felt the training was critical as Care Aims was in some respects very different to how they had practiced and thought about the decisions they made previously.

*"the first thing with Care Aims is getting your head around it ....especially for people like me who trained and worked for the NHS for years. And the way I trained was very much focused on what she could do for the patient, ... that that was difficult to some of us"* (Nurse 1, p.2, line 14-19) (basic theme 3, table 6.6, p.105).

In case study 1 there is a motivation to change and 'unfreeze' the current ways of working. Schein (2010) describes three processes that are necessary for creating the motivation to change. They are: enough disconfirming data to cause serious discomfort; connection of the disconfirming data to important goals; and ideals and enough psychological safety to overcome learning anxiety. In case study 1 it would appear that the Care Aims training provoked the team to think that their traditional way of working was harmful to patients. This then caused anxiety and guilt as it was at odds

with their professional values and culture i.e. a connection created between the disconfirming data and their values. However the team were demonstrating what Schein (2009) refers to as learner anxiety as they expressed fears about not using Care Aims properly. The anxiety expressed by this team is consistent with the evaluation of Care Aims implementation by Roddam and Selfe (2009) who reported that staff had feelings of “*vulnerability, apprehension and uncertainty*” (p.23).

One of the contributory factors to learner anxiety may be the perception of risk to patient care that Care Aims implementation brings. Hagedorn et al (2006) suggest that risk aversion is a key feature in why innovations fail in healthcare organisations, because the occupational norm for all healthcare professionals is to ‘do no harm’ and that any innovation that may be perceived as potentially causing patient harm is resisted.

Schein (2010) identifies several ways to build psychological safety including formal training, involvement of the learner, positive role models and support groups. Whilst formal training had taken place, there had been a delay in further team work to develop and implement Care Aims. The perception that Care Aims was not being used properly in some teams could also suggest a lack of positive role models. This could have been remedied by the use of networking opportunities to share learning between teams to promote best practice and maintain momentum (Hagedorn et al, 2006; Holt et al, 2010).

In this case study there would appear to be evidence of affective commitment (Herscovitch and Meyer, 2002) i.e. a belief that implementation of Care Aims will improve care for patients which is consistent with professional values of wanting to provide the best care for patients but that this is not strong e.g. the team expressed anxiety about implementing Care Aims. There would appear to be parallels with one of the processes that Schein (2010) suggests creates the motivation to change - connection of the disconfirming data to important goals and ideals. This is also supported by Greenhalgh et al (2004) in a literature review exploring spread and sustainability of innovation in the health service where it was identified that innovations that are compatible with the intended users values and norms and perceived needs are more readily adopted. Herscovitch and Meyer (2002) suggest that where there is strong affective and/or normative commitment staff will be willing to do more to support the change such as championing the change rather than merely complying. The lack of strong affective or normative commitment may explain the lack of progress the team

made over a period of twelve months without leadership support from outside the team. AHP 1 said:

*“we felt like we still needed someone to hold our hand”* (AHP 1, p.5, line 5) (basic theme 6, table 6.6, p.105).

Greenhalgh et al (2004) describe the Concerns Based Adoption Model where in the early implementer stage adopters have continued access to what the innovation does, access to sufficient training and support on task issues. This appeared not to be available to this team and may be why the team only demonstrated weak acceptance of Care Aims i.e. support for the change (implementation of Care Aims) is exhibited and the team display positive attitudes but do not do anything actively to implement. Weak acceptance is a point on a continuum proposed by Coetsee (1999) with commitment and resistance at opposite ends. Unike Herscovitch and Meyer (2002) who described types of commitment, building on the earlier work of Judson (1991) Coetsee (1999) suggests a scale of commitment.

The tensions between motivation to change and anxieties about Care Aims and the subsequent impact on implementing Care Aims are demonstrated in this case study. This suggests support for the importance of the change process in addition to the change itself.

### **6.5.7 Theme 2 – Professional Cultures**

The resulting thematic network is for the second global theme of professional cultures (figure 6.9, p.110). Professional culture is frequently identified in the literature as both a barrier and facilitator to integrated team working (table 2.4, p.31). Implementing Care Aims appears to have facilitated the team to explore and reflect on their own and how they view other professional cultures.

## Theme 2: Professional cultures

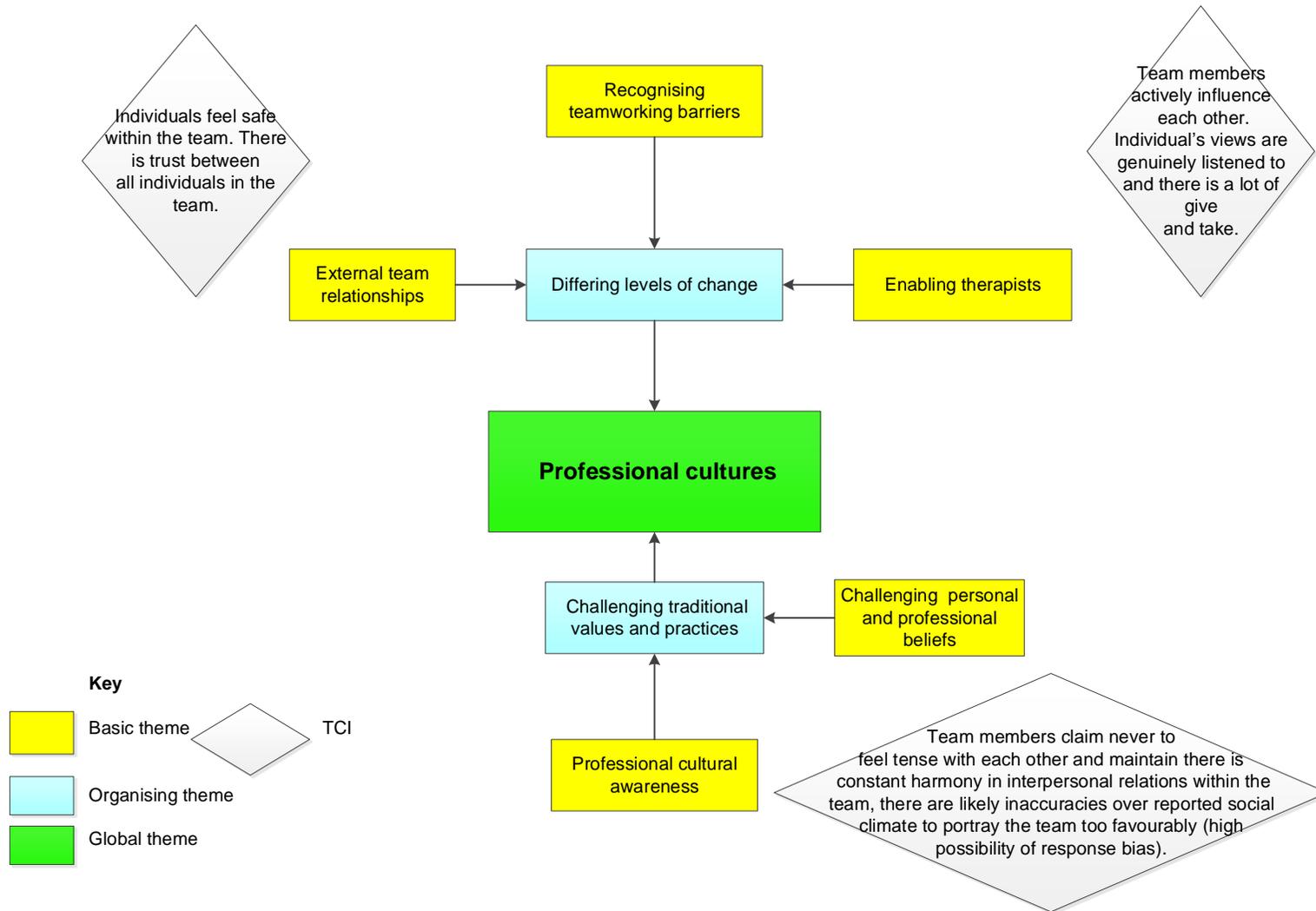


Figure 6.9 Case study 1: Theme 2 - Professional cultures

The team recognised that professions have different cultures and values and implied that Care Aims training facilitated their thinking about this. AHP 1 said:

*“Certainly myself and the physios see things slightly differently I think than a nursing model... and it’s no disrespect to nurses. Nurses are very caring, looking after whereas therapists are enablers and I think sometimes there’s a clash with it”* (AHP 1, p.10, line 2) (basic theme 10, table 6.6, p.105).

Team members described the team differently with AHP 1 describing the team as multi-professional and the other responses describing the team as multi-disciplinary. When asked to describe their role in the team AHP 1 identified that they provided specialist assessments relating to their profession whilst the other respondents were more general in their response and did not refer to their profession in relation to the assessment and treatment they provided.

The role of the patient was also described differently. AHP 1 felt:

*“equally the person has got to participate”* (AHP 1, p.6, line 27) (basic theme 10, table 6.6, p.105).

Whereas Nurse 1 identified:

*“I’ve now come to terms with things now that we can allow patients to make decisions”* (Nurse 1, p.3, line 17) (basic theme 11, table 6.6, p.105);

a *“misplaced sense of responsibility for patients”* (team questionnaire 1, question 11) (basic theme 10, table 6.6, p.105).

Also expressing surprise that patients:

*“do take responsibility for their own healthcare – we can trust them”* (team questionnaire 1, question 11) (basic theme 11, table 6.6, p.105).

Care Aims encourages practitioners to consider 'is it my duty to intervene directly with this person or to support someone else's duty?' with referral criteria for a service being a guide for the boundaries of duty of care with the caveat of 'the more I know the more I have a responsibility and the higher my duty of care and duty to escalate to those who have the resource and who can manage'. The challenge being that 'should I help' does not always translate into 'can I help'. Roddam and Selfe (2009) also noted that Care Aims makes *“more explicit the boundaries of duty”* (p.5). All the nursing respondents expressed fears that clients/patients could fall between services because of their own and other services referral criteria which may have contributed to their reluctance to

fully adopt the care aims philosophy and assume a more task based approach. Roddam and Selfe (2009) in their evaluation of the implementation of Care Aims in a community NHS Trust also found that felt that Care Aims could highlight gaps in commissioned service. However this was perceived in their review as being positive as well as negative. This may also be a reflection on professional culture as all participants in the review by Roddam and Selfe (2009) were allied health professions and in this case study the fears were expressed by nurses. This would appear consistent with the earlier comment by AHP 1 about the nurses being caring compared with AHPs as enablers.

Professional culture appeared to impact on the extent to which individuals were able to support and promote self-management and the level of change required. AHP 1 said:

*“The difference sometimes we’re as therapists we’re looking at more, getting them to participate in active programs or they might look at a change”* AHP 1, p.10, line 17)

whereas Nurse 1 describing their role as:

*“A lot of the time we did just do to patients, who particularly accepted things”* (Nurse 1, p.3. line 9).

However all the respondents gave examples in relation to their own profession with no examples demonstrating an integrated approach to care assessment or planning which may be due to the impact of professional culture.

AHP 1 was more specific when responding about their specialist role compared to the nurses possibly suggesting AHP 1 has a much stronger professional identity. However given the small number of AHP responses this could be due more to the characteristics of the individual rather than professional identity.

Beales et al (2011) suggest that integrated teams need enough collaborative experience to develop a team culture so that the team culture is the predominant culture during times of change and/or conflict rather than their professional culture. In this case study the majority of members of the team have been part of this team for more than 2 years, some for up to 10 years approximately and they articulated different views of team type and role. As the numbers are small in this case study, the results may be due to the characteristics of individuals rather than professional identity although Holmesland et al (2010) comment that professional identity is always dependent on personal identity. However Scott et al (2003) note that one characteristic

of the NHS is the “*robustness of each occupational culture*” (p.25) and that the orientation of staff is professional more than corporate. Bloor and Dawson (1994) go further commenting:

*“Of all the allied health professions (physiotherapists and occupational therapists), this group are the most concerned with the image of their profession”* (p.285)

and therefore their professional identity may be stronger in comparison to their team/organisational identity.

The team acknowledged the different professional views in the team but saw the value this can bring to the service they provide. AHP 1 said:

*“There’s a lot of cross fertilisation of ideas and it does stop and make you think and think about things differently... and the patient will gain from that”* (AHP 1, p.10, line 32) (basic theme 9, table 6.6, p.105).

Care Aims training appears to have facilitated discussion in the team about different approaches to care and to provide the opportunity for the team to develop and agree more consistent working practices. These findings suggest similarities to the case study by Sylvain and Lamothe (2012) where the shared understandings facilitate the team to make sense collectively of events (implementing Care Aims) based on their experience and this has the potential to influence the development of integrated practice going forward that is ingrained in the work activities of the team.

Care Aims appeared to have made the team think about their relationship with other professionals and how other professions consider their duty of care. There appeared to be recognition that they will approach things differently but Care Aims seems to have given team members a confidence to challenge when they feel they were either receiving inappropriate referrals or working outside their team’s scope or duty of care and to consider their relationships with other professionals differently.

The literature frequently identifies clarity about roles, team objectives; culture and professional identity and tight role boundaries as factors that affect effective team working (Cameron and Lart, 2003; Robinson and Cottrell, 2005, Syson and Bond, 2010). Implementing the Care Aims approach appears to have caused the team to both think about their own professional culture and those they work with both in and outside their team. Rather than seeing this as divisive the team appear to acknowledge this and use their Care Aims training to reflect on how duty of care and team role may

be seen by others and how they can better describe their role and the value they bring to others. It is widely acknowledged that cultural change occurs over time and this team are relatively new to using Care Aims and may need more time to consolidate its concepts.

### **6.5.8 Theme 3 – Enablement for Integrated Working**

The resulting thematic network for the third theme is enablement for integrated working (figure 6.10, p.115). The basic and organising themes appear reflective of barriers and facilitators to integrated working identified in the evidence base (table 2.4, p.31).

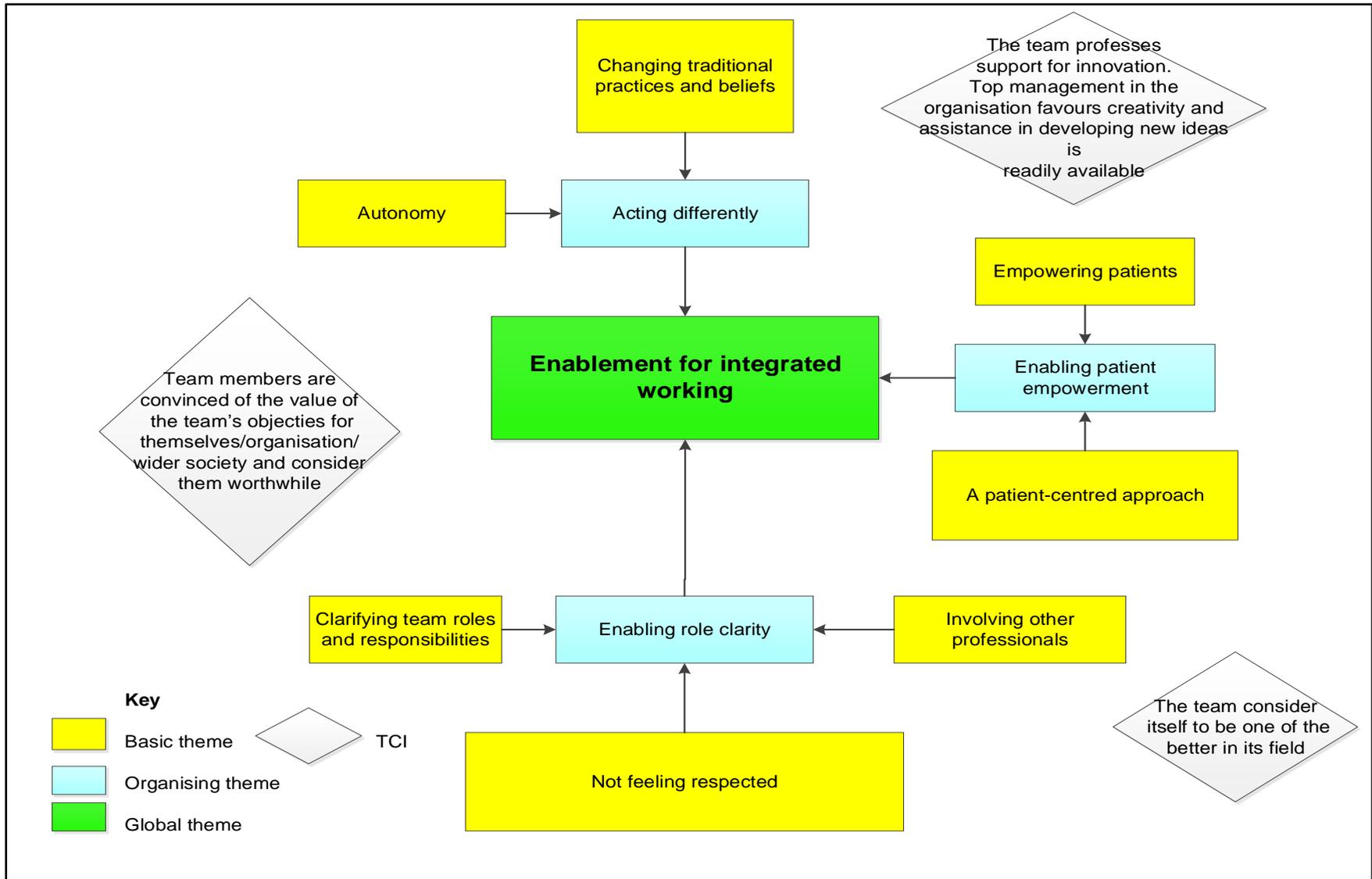


Figure 6.10 Case study 1: Theme 3 – Enablement for integrated working.

*“Better integration can help drive positive change. But in the end this is not about systems, it’s about people. It’s about inspiring local leaders, dedicated and energetic staff and individuals who deserve the most integrated, personalised and empowering care and support we can offer”* (National Collaboration for Integrated Care and Support, 2013).

Care Aims appeared to be seen as an enabler for how the team wanted to work, particularly with other professionals and patients but the team recognises that cultural change is required and this needs to be supported by the organization.

The team describe themselves as a specialist service but expressed they did not feel valued or respected by those who refer into their service. At the same time they saw the value and wanted to work with other professionals. Nurse 1 said:

*“You are doing the patient a disservice if you don’t allow other people to become involved”* (Nurse 1, p.6, line 5) (basic theme 18, table 6.6, p.105).

As described earlier in theme 2, team members viewed the team type, their roles and approach to care differently. The team felt that one of the biggest impacts of the Care Aims training was in helping to clarify their role and responsibilities. Nurse 1 said:

*“For me the biggest impact was understanding where my role ends so it’s not keeping patients on for endless reviews”* (Nurse 1, p.3, line 25) (basic theme 20, table 6.6, p.105).

Nurse 2 felt that using Care Aims:

*“helps with clarity and reduces the risk of unnecessary follow up”* (team questionnaire 2, question 11) (basic theme 20, table 6.6, p.105).

Team members identified that to embed Care Aims they needed to change how they worked. Team members described how they felt liberated and had been given permission to act differently, implying that the organisation had given permission to act differently by commissioning Care Aims. Nurse 1 said:

*“Suddenly I think it becomes quite liberating for a lot of staff because it can be really tough working with patients where there is no improvement but you feel you’ve reached an impasse you don’t have the confidence, the clinical confidence to let go”* (Nurse 1, p.2, line 23) (basic theme 14, table 6.6, p.105).

Nurse 2 describing a patient who had been referred to learn to do a specific intervention for them said:

*“following assessment it became apparent he could not do this. Care Aims helped as that was the end of the episode of care and he was discharged”* (Team questionnaire 2, question 6) (basic theme 14, table 6.6, p.105).

Confidence regarding decision making was frequently cited. This may have also come from discussion with other services. AHP 1 said:

*“Other services that are much further down the line than we are, most of them have said it’s been beneficial and it does change your practice”* (AHP 1, p.5, line 17) (basic theme 15, table 6.6, p.105).

Similar to the findings of Goodwin et al (2014), the team described how Care Aims had helped them clarify eligibility criteria for receiving care, a single point of referral, a single and holistic care assessment, a care plan and support from a multi-disciplinary team of professionals. Whilst not explicit it was implied by the team that one member of the team co-ordinated the care provided by the team for a patient.

Nurse 2 and Nurse 3 described Care Aims as supporting them to work collaboratively with patients:

*“what impact can we help service users manage”* (Team questionnaire 2, question 12) (basic theme 16, table 6.6, p.105)

*“looking at the impact of the problem and setting achievable goals and outcomes”* (Team questionnaire 7, question 4) (basic theme 17, table 6.6, p.105).

Nurse 1 also felt Care Aims helped them to respect when patients chose to not follow their recommendations:

*“this was the patient’s choice and I had more professional confidence in accepting this”* (Team questionnaire 1, question 6) (basic theme 16, table 6.6, p.105).

Care Aims may facilitate integrated working as it encouraged the team to work more collaboratively with patients. This is supported by Shaw et al (2011) giving the example of clinical integration as facilitating the role of patient’s in shared decision making with the underlying principle that:

*“the patient’s perspective is at the heart of any discussion about integrated care”  
(p.7)*

The potential of Care Aims to support self-care was recognised and summarised by Nurse 1 as:

*“It’s about ensuring that you know and define your role and responsibilities with that patient and that patient is clear about what you can offer them and also where their own personal patient responsibility lies as well in improving their own health condition” (Nurse 1, p. 2, line 2) (basic theme 17, table 6.6, p.105).*

However in order to support self-management clinicians also have to overcome their anxieties about Care Aims as described in theme 1 earlier.

The team describe how they wanted to work in the future and described a different relationship with patients, namely with patients as equal partners in their care. The shift from problem solving to impact focused thinking which is integral to the care aims approach appeared to lead to different discussions with patients and referrers about possible solutions with potentially longer term benefits for the patient. Unlike a medical model of care, Care Aims is designed to focus on outcome and requires the clinician to understand the meaning of a problem/diagnosis and its impact on the patient to identify interventions (Malcomess, 2005b) i.e. the focus is on the reason for intervening as opposed to what is being done.

One of the difficulties several members of the team described was the challenge referrers found, changing from focusing on the problems the patient had to impact of those problems for the patient so that the team could assess the clinical risk for the patient.

### **6.5.9 Case Study 1 Summary**

Analysis of case study 1 produced three global themes:

- Change management process
- Professional cultures
- Enablement for integrated working.

The first thematic network explored that the team recognised that current ways of working were not in the best interests of patients or the team and the team wanted to change how

they worked. The team were keen to implement Care Aims 'properly' but were anxious and felt they were still learning. The results suggested that the level of change differed according to professional culture, particularly in terms of how the relationship with patients was viewed e.g. participatory or paternalistic.

The second thematic network explored how the team felt about their own and other professional cultures. Care Aims training appeared to have facilitated conversation about professional culture and how professional culture can influence how team members work together and provide care in an integrated way.

The third thematic network explored enablement for integrated working. Care Aims is perceived as an enabler for this as it is considered by the team to be a patient centred approach where patients are viewed as equal partners and by providing a framework for interpreting roles and responsibilities.

Together the global themes suggested that Care Aims could be successfully implemented, support integrated team working and provision of integrated care. This case study also suggested that Care Aims may be more challenging for some staff groups to implement.

## 6.6 CASE STUDY 2

Section 6.6 presents and analyses the finding for Case Study 2.

### 6.6.1 Response Rates

The response rates for the questionnaires and interviews are shown in table 6.7 (p.120).

Table 6.7 Case Study 2: Response rates

| Questionnaire/Interview                  | Number completed | Response rate |
|--|------------------|---------------|
| Team Care Aims questionnaire             | 2/8              | 25%           |
| Patient Care Aims Questionnaire          | 7                | *             |
| Semi-structured interview – team members | 1/8              | 12.5%         |
| Semi-structured interview – patients     | 0                | N/A           |

\*Whilst the team had been provided with 50 questionnaires for patients it was unclear how many of the questionnaires the team had been provided with were given to patients. Therefore the response rate could not be calculated.

### 6.6.2 Results from the Team Care Aims Questionnaires

#### Respondents

Both respondents to the team Care Aims questionnaires were AHPs (AHP 1 and AHP 2) but from different professions: OT and physiotherapy. Both had been working with the team for more than 2 years and were band 5 or 6.

#### Perception of team type, role and function

Both respondents described the team function in a similar way but the team type differently with AHP 1 using the term interdisciplinary and AHP 2 using the term multidisciplinary. This may be profession related as similar to case study 3; interdisciplinary appears to be a term used mainly by OTs.

#### Implementing and using Care Aims

Both respondents described Care Aims as a method of caseload management. Both noted that training had taken place which both had attended but the level and type of training had

varied between team members. Both respondents gave contrasting views regarding Care Aims implementation and use within the team with AHP 2 describing how they were using Care Aims and AHP 1 stating that Care Aims was not being used as it was not effective in their team.

AHP 2 who was using Care Aims had found the goal planning sheet useful and noted that the planning sheet was better than what the team had used previously as it provided a good visual aid for staff and helped motivate patients.

Both AHP 1 and AHP 2 identified that the triage form was not useful and AHP 1 felt that the form they had used previously had been more sensitive. One noted that it was very time consuming too.

When asked about using Care Aims AHP 2 felt that the episode plans were good whilst AHP 1 felt that Care Aims did not alter her thinking because the service was time limited and episodes of care were used already.

Both AHP 1 and AHP 2 described aspects of Care Aims particularly the triage process as not suitable and time consuming. However the goal planning approach was felt to be useful by AHP 2 perceived by to be of value to themselves and patients.

### **6.6.3 Results from the Team Care Aims Interview**

#### **The Interviewee**

The interviewee (AHP 1) had already completed a team Care Aims questionnaire and some of the responses at interview appeared to contradict the questionnaire responses. At the time of the interview, AHP 1 had left the team and was working for the same organisation in a different clinical role.

#### **Perception of team type, role and function**

AHP 1 described the team as an interdisciplinary team because the team contained a range of professions. AHP 1 went on to note that the initial assessment could be completed by any of the clinicians unless there was a specific nursing element and then it was passed to the nurse. This was then qualified and noted as being the same for other

professions too. AHP 1 described the role of the team as undertaking a holistic assessment in relation to their specialty, identifying risk factors and the interventions focussing on minimising those risk factors.

### **Implementing and using Care Aims**

Care Aims was described by AHP 1 as an approach for caseload management to help manage caseloads across the team. It was reported that the team had tried to use Care Aims in the triage process but this had been unsuccessful. Reasons given were that it was time consuming and the triage form the team had previously used was considered by the team to be more sensitive.

All the team were reported as going on the training course but that the level of training received had varied across the team. AHP 1 felt the training she had received had been poor partly due to the variety of teams on the training but also due to some of the teams attending the training appearing to be very negative about Care Aims so the training became more of a debate rather than a learning experience. AHP 1 felt that some of the trainers were not very experienced. When AHP 1 attended Care Aims training the organisation had started to deliver Care Aims training using its own staff rather than Kate Malcomess Consultancy. AHP 1 felt this had affected the quality of the training. AHP 1 felt that those members of the team who had received more training were more engaged and positive about using Care Aims.

AHP 1 reported that the team had decided to start implementing Care Aims within their triage process first because it was a “*set bit*” (AHP 1, p.2, line 20) within the pathway. The decision to do this was described as being the team manager’s and that the team went along with this although the team were described as being good at trying new things. AHP 1 described how the team ‘got rid’ of the parts of Care Aims that they did not like but felt they were using the principles of Care Aims if not the paperwork. This appeared to contradict the questionnaire response which said that Care Aims was not being used in the team. Changes the team had made to how they were using Care Aims over a period of time were described and how these would be frequently debated in team meetings. AHP 1 said the team repeatedly told the team manager that they felt Care Aims was taking up a lot of their time and impacting on their ability to manage their caseloads. Whilst it was felt that the team manager was keen for the team to use Care Aims, the team were able to

adapt and change how Care Aims was used and that some frank discussion had taken place to agree the way forward.

Throughout the interview AHP 1 repeatedly used the word 'justify' when talking about implementing care aims, other changes or in relation to decision making. Care Aims was labelled as subjective and deemed to be dependent on who was asking the question and their level and type of experience. AHP 1 also felt it was hard for patients to make the connection between their health problems and impact on their life. The Care Aims triage tool was considered to be '*vague*' (page 3, line 16) and not adapted to their team specifically, again appearing to challenge the perceived subjectivity of Care Aims. AHP 1 also felt that Care Aims had its own language and terminology and that the team did not use Care Aims language with patients as it was felt this would complicate things more and that what mattered to patients most was having a clear plan. Examples of this were clinical risk, episodes of care, the 'care aims' themselves. It was reported that patients had responded well to the goal setting sheet but again this could be subjective depending on who was completing it with the patient.

AHP 1 described how with the other AHP, joint assessments were done to avoid having to refer on to each other but that if a referral to the nurse was required this would be identified on the goal setting sheet. AHP 1 identified that they had been trained in the basic nursing elements and also in AHP elements from other professions and that this was liked by patients. This was in place prior to Care Aims training. It was reported that there were some interprofessional difficulties within the team for examples when talking about caseload size for different professions. AHP 1 felt other professions did not understand the complexities of her role and needing to justify caseload size. However turnover within the team was reported as low and that many of the team had worked together for a long time, describing the team as close knit and open with each other.

#### **6.6.4 Results from the Patient Responses to the Care Aims Questionnaires**

Patients generally identified that the team was made up from 2 AHP groups and nursing staff. However some respondents left blank the questions asking about the role of the team and the team type. Overall the patient responses to each question were much shorter than the team responses.

The responses from patients were consistently positive about the service, approach to care and particularly goal planning. All the responses suggested the respondents felt they were playing an active part in their care, felt empowered and understood what they needed to do. Examples were given of individual tuition, patients feeling able to take part, that treatment provided being useful and had been put into practice. Responses to the question asking about what they hoped would happen and how they felt now included:

*“I know why I am doing this and how to put it right”* (Patient questionnaire 1, question 11)

*“I feel a lot more confident”* (Patient questionnaire 2, question 11)

*“more philosophical”* (Patient questionnaire 4, question 11)

*“very hopeful “* (Patient questionnaire 6, question 11).

None of the respondents gave any negative replies about this team and many of the questions where a negative response was being elicited were left blank. One reply was very negative about another service but the respondent also identified their plan of action too.

#### **6.6.5 Resulting Thematic Network**

Similar to case study 1 the thematic networks were developed following the process described in section 4.12. The 26 basic themes were clustered and 8 organising themes identified. The eight organising themes were then summarised into three global themes (table 6.8, p.125).

Table 6.8 Themes generated from case study 2

| Basic theme                                | Organising theme                    | Global theme   |
|--|-------------------------------------|--|
| 1. Task focussed                           | 1. Tasks and processes              | 1. Change process  |
| 2. Choice                                  |                                     |  |
| 3. Paperwork                               |                                     |  |
| 4. Ineffectiveness                         | 2. Valuing Care Aims                |  |
| 5. Subjectivity                            |                                     |  |
| 6. Leadership and vision                   |                                     |  |
| 7. Care Aims is difficult                  |                                     |  |
| 8. Previous approach preferred             | 3. Importance of training           |  |
| 9. Training and engagement                 |                                     |  |
| 10. Inconsistent training                  |                                     |  |
| 11. AHP mutual respect                     | 4. Professional relationships       | 2. Professional relationships and team climate and culture |
| 12. Professional disrespect                |                                     |  |
| 13. Misunderstanding roles                 |                                     |  |
| 14. Role extension                         |                                     |  |
| 15. Team type perception                   | 5. Positive team climate            |  |
| 16. Cohesive team                          |                                     |  |
| 17. Feeling special                        |                                     |  |
| 18. Feeling empowered                      |                                     |  |
| 19. Feeling innovative                     |                                     |  |
| 20. Patients value goal setting            | 6. Being partners in care           |  |
| 21. Patients understand their role in care |                                     |  |
| 22. Being the expert                       | 7. Being the expert                 |  |
| 23. Perception of partnership working      |                                     |  |
| 24. Being paternal                         |                                     |  |
| 25. Positive patients                      | 8. Overly positive patient response |  |
| 26. Perceptions of integration             |                                     |  |

### 6.6.6 Theme 1: Change Process

Similar to case studies 1 and 2 the first thematic network explores the ‘change process’ (figure 6.11, p.126). This thematic network appears to show opposition and no motivation to change i.e. the situation stays frozen.

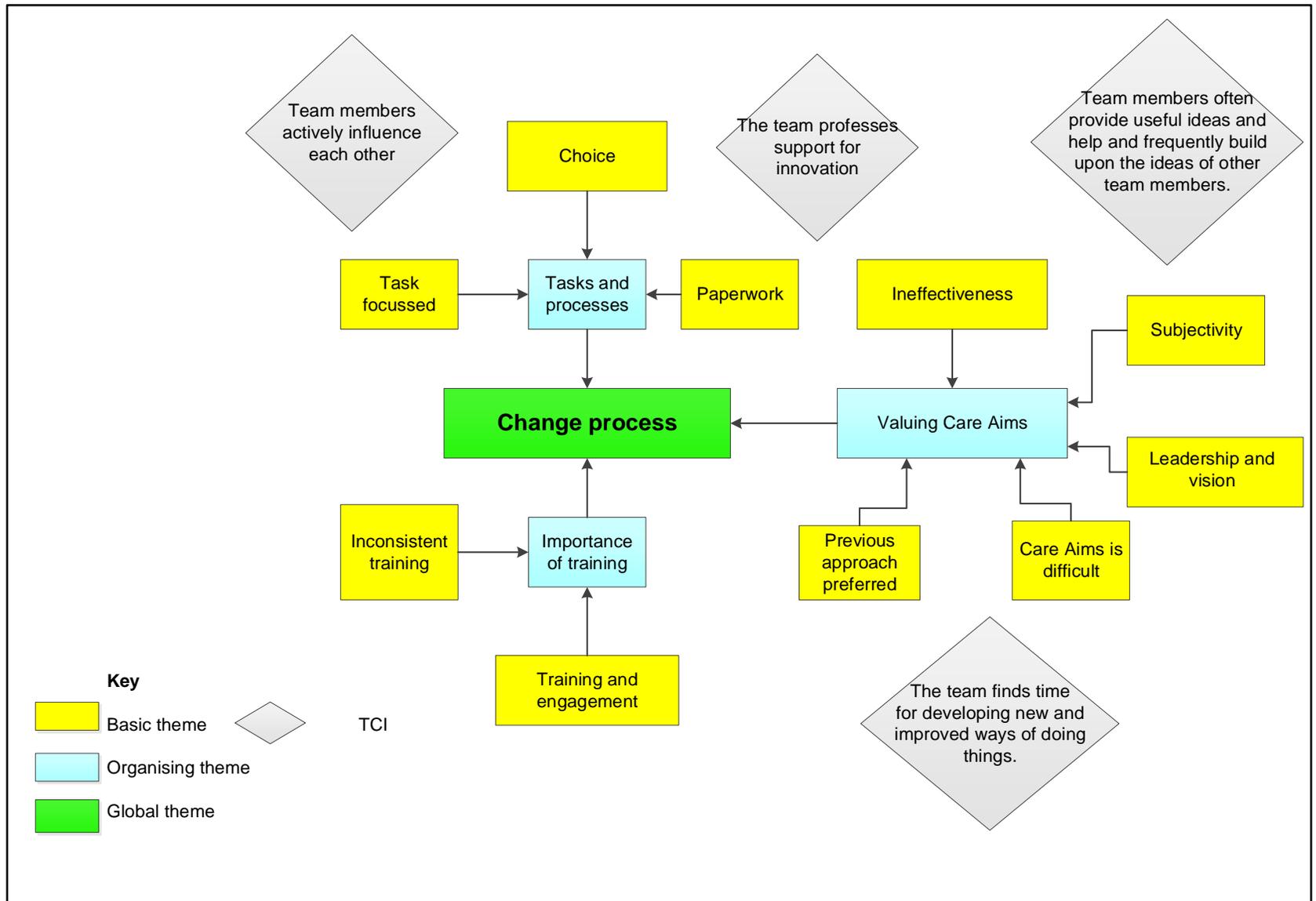


Figure 6.11 Case study 2: Theme 1 - Change process

Care Aims was described as being no better than the systems and approaches the team were currently using and as not effective for their team (figure 6.11, p.126). Care Aims was perceived as being time consuming and the team felt their own triage form for example was much better. However goal setting with patients was described in more positive terms. Care Aims was not seen as being part of the team's vision for the future which appeared to be reinforced by the team leader. AHP 1 described repeated discussions at team meetings about what was and was not working and making adaptations to the model and related paperwork. She then recalls the team leader's reaction to the feedback from the team about Care Aims not working and their understanding of this:

*"Give it a go; see you how you find it. So it was quite open"* (AHP 1, p.4, line 15) (basic theme 6, table 6.8, p.125).

Care Aims was described as being subjective which appeared to cause difficulty in accepting the approach as it was described that this could vary greatly according to which clinician assessed and also the patient's response. In addition there was a perception that the tools were not specific to their team which also added to the subjectivity of the assessing clinician. Care Aims was viewed as a case management approach and a series of tools and processes which could be adapted or abandoned: parts of the approach used and others which the team felt did not work for them or were not suitable dropped. AHP 1 said:

*"I think we're using more of an alien version of Care Aims."* (AHP 1, p.9, line 27) (basic theme 2, table 6.8, p.125).

Both AHP 1 and AHP 2 described participating in training but the extent of this appeared to vary significantly with AHP 1 observing:

*"I think the people who'd had the longer training were probably more, I don't know the right term, more up for it really and more involved in trying to get it to work rather than myself and \_\_\_\_\_ (name removed to protect anonymity). We were just dragged along afterwards and we were sort of 'we can either make this work or we can't use it really. It doesn't make that much difference'".* (AHP 1, p. 8, line 34) (basic theme 10, table 6.8, p.125).

Lewin (1947) identified that there had to be a motivation to change to 'unfreeze' the status quo. Schein (2010) building on this identified three processes which all have to be present to unfreeze the situation. These are enough disconfirming data to create and stimulate a desire to change: a connection with the disconfirming data to cause anxiety or guilt in that

if change does not occur then something bad will happen; sufficient psychological safety to overcome learning anxiety so that the new way of working is seen as achievable; and the learning process will not be too difficult.

Unlike case study 1, in case study 2 it would appear that none of these factors were sufficiently present to create motivation to change. The team felt that Care Aims was no better than their current way of working and the team did not describe their performance in any negative way and this appeared to be supported by the positive responses from patients i.e. there was no disconfirming data. The team appeared to suggest they could control how much if any of Care Aims they implemented indicating no anxiety or guilt about not implementing Care Aims. Learning anxiety appeared to be expressed in the basic theme (table 6.8, p.125) 'Care Aims is difficult' and described as "*time consuming*" (Team Questionnaire 1) suggesting insufficient psychological safety.

Pettigrew and Whipp (1991) identified eight receptive contexts for change some of which resonate with Schein's (Schein, 2010) theory of managed change previously described. Whilst the TCI suggested a climate supportive of innovation (figure 6.2, p.93) other factors did not appear to be present such as the quality and coherence of policy and the availability of key people leading change.

Weiner (2009) identifies that organisational readiness for change is a critical precursor to the successful implementation of complex changes in healthcare settings and states that a receptive context may not readily translate into readiness to change and that the content of change matters as much as the context. For example AHP 1 stated that:

*"They're pretty good at introducing things or trying new things"* (p.2, line 31) (basic theme 19, table 6.8, p.125).

However in this instance the team appeared to be resistant to introducing this change.

Weiner (2009) suggests the conditions that promote readiness for change are team members wanting and valuing the change enough to committing to its implementation and having a sense of confidence they can implement the change (based on task demands, resource availability and situational factors) similar to Schein's theory of managed change previously described (Schein, 2010). In this case study certainly the first factor and partly the second factor were not present.

It is also possible in case study 2 that there was an element of 'groupthink' which influenced the implementation of Care Aims. Janis describes groupthink as a group where *"loyalty requires each member to avoid raising controversial issues"* (1982, p.12). Janis (1982) identified that certain conditions tended to be present when groupthink arises. These included that the group was a highly cohesive group of individuals more concerned with maintaining cohesiveness than decision making. Whilst the work of Janis, particularly in relation to the influence of group cohesiveness was not fully supported by other studies (Park, 2000, p.873), Steiner (1982) suggested it was the desire for cohesiveness rather than the actual presence that was influential. In this case study whilst the team had different perceptions about the present team culture, the dominant preferred culture was clan, suggesting aspirations for improved team working. This and the high social desirability scores could indicate the team's priority for cohesiveness rather than decision making. This is supported by Anderson and West (1996) who noted that social desirability may correlate with aspects of group consensus. For example a very high social desirability response may manifest in a dysfunctional team as group think.

The other factors Janis (1982) identified were that the group insulated itself from information and opinions from outside, the group rarely engaging in any kind of systematic search and going with the first available option on which there is consensus and the group is under pressure to make a decision. AHP 1 recalled:

*"It was pretty much every time we got together as a team, we'd look at how it was working, what was working, what wasn't and make adaptations at each meeting and see how that's run on for the next one really."* (AHP 1, p4, lines 16-18) (basic theme 2, table 6.8, p.125).

This global theme appears to support the findings of Bate et al (2002) who reviewed the effectiveness of a series of improvement projects in the NHS and concluded that:

*"proper implementation is key and may even make the difference between failure and success in all aspects of development"* (p. 108).

### **6.6.7 Theme 2: Professional Relationships and Team Climate**

The thematic network for the second theme explores the apparent inconsistency between professional relationships and team climate (figure 6.12, p.131).

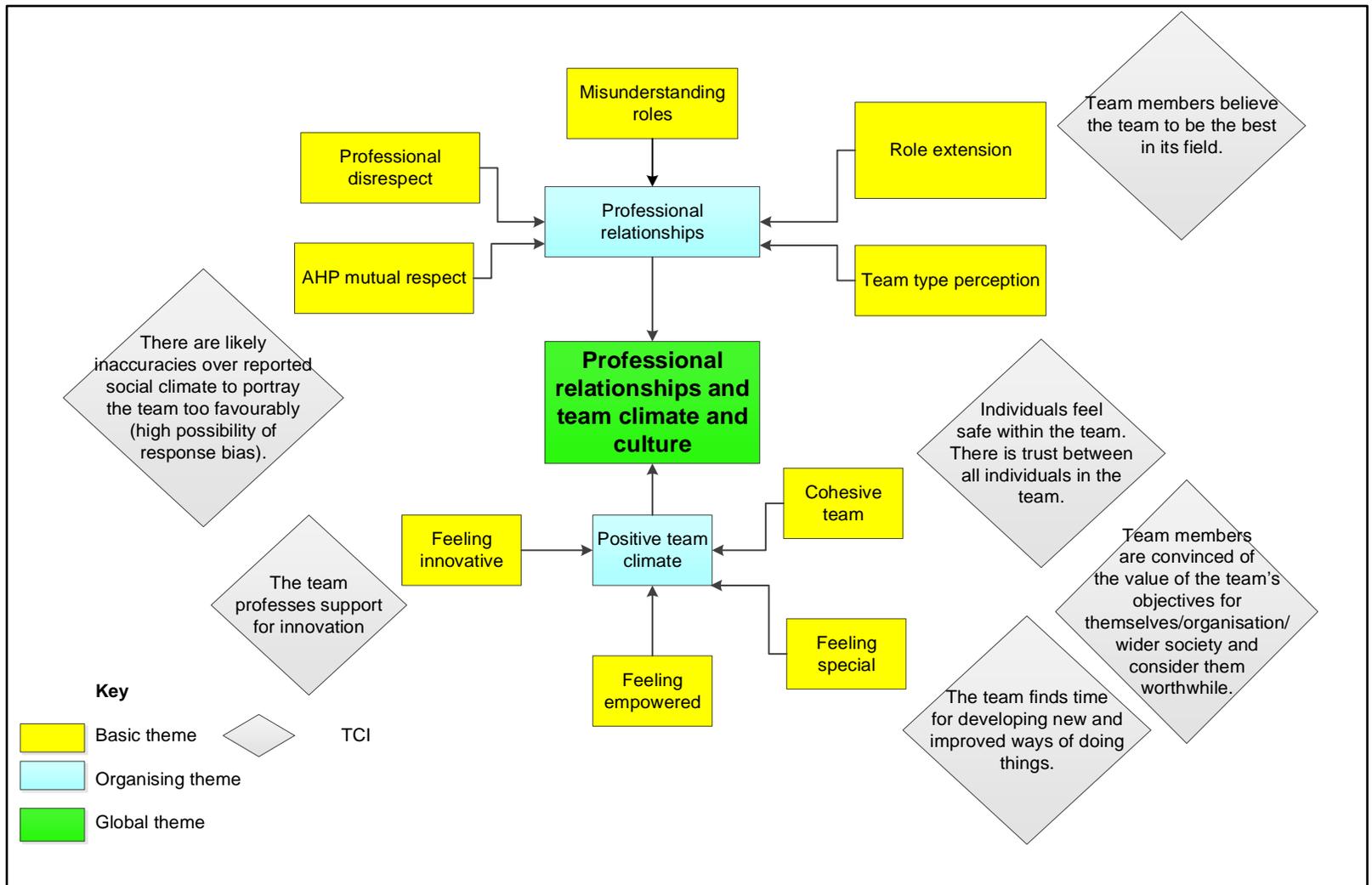


Figure 6.12 Case Study 2: Theme 2 – Professional relationships and team climate

From the responses it became apparent that the levels of respect varied between professions although caution should be applied to these findings due to the low response rate and both the team respondents were AHPs. AHPs appeared to view each other as equals whereas the nurse appeared to be viewed less positively. Joint assessments by different AHPs were described as usual practice with collaboration to agree joint goals but if a nursing specific element arose that the AHPs did not feel they could address, it would be identified on the goal sheet and an internal referral made to the nurse. This also suggested the team were not working in a particularly integrated way. It was described that team members had been trained in the basics of each other's assessment, the AHPs chose to assess together as the vast majority of patients were described as needing both.

When describing the team phases such as 'try anything', 'close knit' were used along with a common description about the role of the team. All of these suggest a positive team climate. However the team climate inventory results suggest:

*"there are likely inaccuracies over reported social climate, to portray the team too favourably" (p.5).*

This would appear to support the emerging view of different levels of respect between team members (figure 6.12, p.131) and the overarching theme that there is an inconsistency between team climate and levels of respect between professions. Nancarrow et al (2013) in a review of interdisciplinary team working identifies that:

*"collaboration is acknowledged as an important component of team process" (p.2)*

Also that respect and trust is integral. The comments by AHP 1 could be considered as showing a lack of respect towards nurses. Nancarrow et al (2013) also reflect that given that team members are from different professions, shared decision making may be a challenge particularly when there are complex hierarchical relationships as there appears to be in case study 2.

Similarly Kvarnstrom (2008) and Beales et al (2011) argue that when negotiating during interprofessional interactions, profession is the reference point and this causes a tension between disciplinary and interdisciplinary logic. This also supports the earlier findings of Scragg (2006) who evaluated the integrated team management in community health teams and found that organisational change and the introduction of integrated team

management was in fact reinforcing professional culture although Scragg (2006) does acknowledge the evidence in his study was limited. Mackay (2007) suggests that profession as the reference point may be more challenging for OTs as professional insecurity and identity confusion experienced by OTs is well documented and states that “despite much work in this area occupational therapy identity remains as elusive as ever (p.96). Schoeb et al (2014) had similar results for physiotherapy in their study leading them to conclude that “*physiotherapy has not established a firm identity yet*” (p. 89). This differed from Baxter and Brumfitt (2008) who felt in their study that physiotherapists had a very clearly defined role and responsibilities.

The basic theme ‘misunderstanding roles’ (figure 6.12, p.131) would appear consistent with the findings of other studies and reviews (Kvarnstrom, 2008; Larkin and Callaghan, 2005; Maslin- Prothero, 2010). Hudson (2007) and Borril et al (2000) suggest that where one profession within a team feels they have or is perceived to have a higher status than other professions this will impede team working. AHP 1 appeared to suggest that the AHPs had a more important role than the nurse (figure 6.12, p.131):

*“The nurse was just generally monitoring people so she wasn’t actually taking, doing active treatment”* (AHP 1, p.8, line 14) (basic theme 12, table 6.8, p.125).

Whilst the dominance of the medical profession is well documented, particularly in relation to the nursing profession, little literature could be found regarding status and hierarchy between AHPs and nursing.

Beales et al (2011) assert that healthcare professionals need enough interprofessional collaborative experiences to be able to develop interprofessional team collaboration and that structures/processes with clear role and responsibility definition must be in place to strengthen team rather than professional culture. Barrett et al (2005) explore this further stating that:

*“Confidence and competence are crucial to interprofessional working”* (Barrett et al, 2005, p.20).

Expanding further, Barrett et al (2005) propose that an individual can be psychologically dependent on their identity for professional identity for the own sense of inner wellbeing, when there is role overlap and blurring of boundaries this can lead to feelings of anxiety,

role insecurity and reduced professional confidence. In this case study whilst both AHP 1 and AHP 2 had been with the team for more than two years they were working at band 5 or 6 and it may be that they did not have the level of professional confidence and competence for their professional identity to feel secure to them as individuals. The way the team describe integrated working may offer some support for this. AHP 1 describes how she had been trained to undertake nursing skills such as blood pressure monitoring, medicines awareness, bone health assessment and physiotherapy skills such as use of walking aids and exercise. AHP 1 felt that unlike the nurse she was assessing and treating rather than just monitoring.

Integrated working in this team appeared to be about team members having extended roles in the form of horizontal role substitution where professions within a team with a similar level of training and expertise take on roles that are normally the domain of another discipline (Nancarrow and Borthwick, 2005). Case study 2 had similar findings to those of Nancarrow (2004) in that AHPs had the greatest areas of overlap whereas nursing roles were seen as being more discrete. This is similar to the findings of Baxter and Brumfitt (2008) who explored interprofessional working in stroke care who also found a blurring of boundaries particularly between OT and physiotherapy and less so between other professions.

In case study 2 both respondents had been in the team for more than 2 years and staff turnover was described as very low by AHP 1 suggesting that the team members should have had sufficient collaborative experiences. Whilst AHP 1 described roles and responsibilities across the team and the relationships across the different professions this is not evident in any of the responses from AHP 2, which could either be interpreted as there being no collaborative working, or that AHP 2 was working so collaboratively that team culture overrides professional culture. The overly positive social desirability team climate result would suggest support for the former. However other reported aspects such as the team being "*close knit*" (AHP 1, p. 9, line 36), TCI results for innovation, the team meeting frequently (interaction frequency score of 10) which Cameron and Lart (2012) in their review of the factors that promote and hinder joint working suggest can help overcome professional differences, and the previous discussion about groupthink may be more indicative of the lack of leadership provided to the team. Leadership in integrated teams is recognised as critical with Leutz (2005) changing his original law:

*“The one who integrates calls the tune”* (Leutz, 1999, p. 97) to

*“Put the right person/organisation in charge of integration”* (Leutz, 2005, p.8).

This is further supported by West et al (2012). In a study exploring the effectiveness of multi-professional team working in mental health care, they identified as their second recommendation the provision of good leadership (the first being clarifying purpose and function of the team). West et al (2012) found that lack of leadership during times of change particularly in relation to implementing decisions and making changes to service changes was *“particularly damaging”* (p.132). Interestingly this was the only case study where the team leader did not complete a Care Aims questionnaire.

The inconsistency between professional relationships and team climate is not unexpected as professional cultures and lack of clarity about role are widely reported as barriers to integrated team working (Maslin-Prothero, 2010; Cameron and Lart; 2012).

### **6.6.8 Theme 3: Perception of team/patient relationship**

The next thematic network is for the third theme ‘perception of team/patient relationship’ (figure 6.13, p.136). This thematic network explores the different perceptions of the relationships between team members and patients and how they view each other.

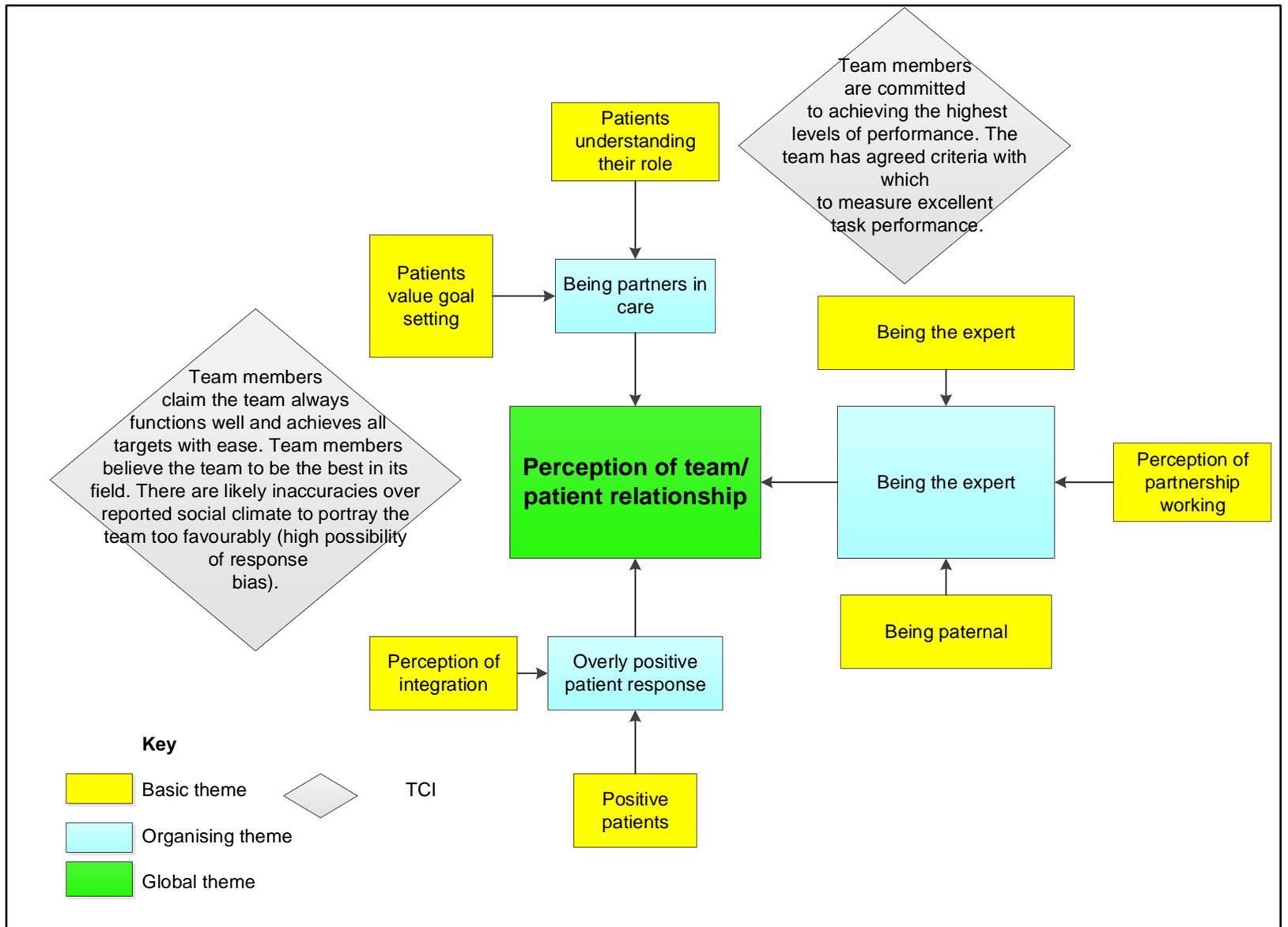


Figure 6.13 Case Study 2: Theme 3 – Perception of team/patient relationship

*“The service user is the organising principle of integrated care....There is a need for a shared vision in which the service user perspective and patient experience is central”* (Shaw et al, 2011, p.20)

This is one of four key lessons identified by Shaw et al (2011) in their research report exploring integrated care in the NHS. Sadly it is an area where there is little published research with the majority of studies about integrated care drawing on the views of staff (Institute of Public Care, 2013; Maslin-Prothero and Bennion, 2010).

The response from AHP 1 particularly suggested a paternalistic view of patients hinting that team members were cleverer than patients. This example was given when discussing whether Care Aims was used with patients:

*“we have enough barriers with language with patients so to introduce that as well. It was just, I don’t think it even came into the discussion about trialling that because we want to make it as easy and simple for patients as possible really”* (AHP 1, p. 4, line 23) (basic theme 24, table 6.8, p.125)

and

*“The difficulty was about asking the person about their judgement whether that impacts on their health. It was quite difficult for patients to actually make that linkage”* (AHP 1, p.3, line 10) (basic theme 22, table 6.8, p.125).

Team responses suggest that team members think they are working in partnership with patients such as using the goal setting sheet to jointly plan goals. Patient responses did not mention joint goal setting specifically. Mudge et al (2014) in a study using autoethnographical methods concluded that as physiotherapy practice is typically underpinned by a biomechanical discourse, which separates the mind and the body this, limits physiotherapist’s ability to manage aspects of person-centred practice. Patient responses did suggest that they felt empowered and were clear about their role in care. Responses described an increase in confidence and tended to be optimistic in outlook. As Patient 1 said:

*“I know why I am doing this and how to put it right”* (Patient questionnaire 1, question 11) (basic theme 25, table 6.8, p.125).

Staff attitude may be reflective of the change in government policy and trends in integration. Shaw et al (2011) reflected that only from 2000 onwards did patient centred care and shared decision making start to appear and was highlighted in the 2000 NHS Plan (HMSO, 2000). The Health Foundation (2014) describe person centred care as an emerging and evolving area despite it being used more than 50 years ago by

psychologist Carl Rogers (Health Foundation, 2014). It is acknowledged in the literature that for professionals to work with patients as partners in care they need to move away from traditional models of care where they see themselves as the primary decision maker (Coulter et al, 2013). Coulter et al (2013) recommend that processes have to be in place to help healthcare professionals identify and include the patient's contribution to the care planning process and summarise the main change for clinicians as:

*“recognising the information about the lived experience and personal assets that the patient brings to the care planning process is as important as the clinical information in the medical record” (p.7).*

It is possible that staff have not had training to facilitate a more patient centred approach even though they appear to be implementing processes such as the goal planning sheet that aim to facilitate this. It is also possible that staff actually think they are working in partnership with patients despite evidence suggesting a paternalistic approach. Both Coulter et al (2013) and Epstein and Street (2011) note that it is not unusual for clinicians to think they are working in a collaborative way with patients to find out on training courses that their *“usual consulting style is not as collaborative as they thought it was”* (Coulter et al, 2013, p.12) which may be the case in this team.

Maitra and Erway (2006) in a comparative analysis of patient-centred practice in OTs and their patients did demonstrate a perception gap between the OTs and their patients. Epstein and Street (2011) also suggests that patient centred care may be at odds with an evidence based approach to care. AHP 1 frequently cited the subjectivity of Care Aims as a cause for concern and used the word ‘justify’ several times during their interview. It is possible that AHP 1’s need for objectivity and a more scientific approach to care is influencing their approach to a more person centred approach and inciting them to act in a more paternalistic manner. This may be a manifestation of the lack of professional confidence discussed earlier as part of theme ‘Inconsistency between patient views and staff views of patients’. Pelzang (2010) reviewing the literature confirms the need for professionals to be competent and knowledgeable in order to be able to implement patient-centred care.

None of the patient responses contained any negative replies and responses to questions that would elicit a negative response were either left blank or did not state any negative feedback. The only negative feedback on one questionnaire was in relation to another non-NHS service.

Several studies (Breemhaar et al , 1990; Visser et al, 1989) have suggested that older patients, particularly females have a stronger tendency to adopt a more socially desirable attitude and this is also the case when patients are asked to give feedback during their episode of care compared to following discharge. As the patient questionnaires were given to patients during the course of their care and the service treats patients aged 65 and over, it is possible that patients have given overly positive responses suggesting a likelihood of response bias in terms of social desirability.

### **6.6.9 Case Study 2 Summary**

Analysis of case study 2 produced three global themes:

- Change process
- Professional relationships and team climate and culture
- Perception of team/patient relationship

The first thematic network (change process) explored the team's lack of motivation to change. The process of change and team's receptiveness to the change appeared to impact significantly on implementation. The second thematic network explored the relationships between the different professionals in the team. Whilst a positive relationship was reported between the AHPs this did not appear to extend to the nurse. These relationships appeared at odds with the team climate results and how the team reported themselves through the interview and questionnaire. The third thematic network explored the different perceptions that emerged of the patient-staff relationship, with patients and staff appearing to have very different perceptions.

Together the three thematic networks suggest that in case study 2 Care Aims is unlikely to be successfully implemented:

- the patient determining the impact of their condition on them and identifying goals based on this. Team members think they are working in partnership with patients but also describe a paternalistic relationship with them. There is a high likelihood of positive social desirability response from patients suggesting that patients do not see themselves as partners.
- For Care Aims to be successfully implemented in an integrated team, professionals need to work in partnership with each other. They need to have a clear understanding of and value and respect each other's' roles which includes

trusting each other's judgements. The results from the team Care Aims questionnaires and interview and TCI suggest this is not the case.

## 6.7 CASE STUDY 3

This section reports and analyses the results for case study 3.

### 6.7.1 Response Rates

The response rates for the questionnaire and interviews are shown in table 6.9 (p.141).

Table 6.9 Case study 3: Response rates

| Questionnaire/Interview                  | Number completed | Response rate |
|--|------------------|---------------|
| Team Care Aims questionnaire             | 12/18            | 66.7%         |
| Patient Care Aims questionnaire          | 1                | *             |
| Semi-structured interview – team members | 2/18             | 11.1%         |
| Semi-structured interview – patients     | 1                | *             |

\*Whilst the team were given 50 questionnaires to give to patients. it was unclear from how many of the patient questionnaires were distributed therefore the response rate cannot be calculated.

### 6.7.2 Results from Team Care Aims Questionnaires

#### Respondents

The respondents were all AHPs from each of the three professions represented in the team (OT, physiotherapy and SLT), or generic rehabilitation assistants. One quarter of the respondents were rehabilitation assistants. Whilst the team included psychologists, none responded.

The respondents ranged from bands 3-7 and were aged between 18-50 years old. Nine of the 12 respondents had worked in the team for more than 2 years and the remaining three had worked in the team for more than one year.

#### Perception of team type, role and function

The majority of the respondents described the team as multidisciplinary. Four respondents (AHP 1, AHP 2, AHP 7, and AHP 8) described the team as interdisciplinary. Two of these were OTs. AHP 8 in addition to describing the team as multidisciplinary also described the team type as integrated and AHP 2, also added interdisciplinary to their response of multi-disciplinary. All respondents described the team's function in a similar way with varying additional detail. Four of the respondents

chose to identify the professions represented in the team in their answer. Three of these were rehabilitation assistants (RA). The rehabilitation assistants were the only ones to mention in their questionnaire responses the presence of psychologists in the team with RA 2 using the words: “*with psychology input*” (Team questionnaire 4, question 1) and RA 3: “*also psychology*” team questionnaire 5, question 1). Surprisingly one of the team leaders (AHP 8) only identified the team being made up of speech and language therapists, OTs, physiotherapists and rehabilitation assistants.

### **Implementing and using Care Aims**

Three members of the team (AHP 3, AHP 6 and AHP 9) reported that Care Aims was already being used when they joined the team. These three members of the team included all three AHP professions in the team and were all band 5 or 6 staff. The remaining respondents except RA 1 all identified that the team had attended formal Care Aims training and that the team had adapted the Care Aims paperwork for the team. Many of the responses described how Care Aims had facilitated setting realistic goals with patients and clarified roles and responsibilities during the rehabilitation process. Several gave negative responses about the length of time required to complete Care Aims documentation. Several responses identified that Care Aims was used for their whole caseload with AHP 2 saying “*this is integrated into our work so this is the norm*” (respondent 11, q.12).

### **6.7.3 Results from Team Care Aims Interviews**

#### **The interviewees**

Both the interviewees, AHP 1 and AHP 2 were band 7 and in leadership roles within the team. They were from different professions and both had worked in the team for more than 2 years.

#### **Perception of team type, role and function**

Responses to team type varied. AHP 1 described the team as an integrated team including OT, SLT, physiotherapy, rehabilitation assistants and psychology, referring later in her interview to the four disciplines in relation to goal setting. However AHP 2 only described the team as multidisciplinary working in an interdisciplinary way, referring to psychology once when describing how goals are set:

*“goals are from each of the three disciplines or what or four if there’s something that involves the psychology aspect to it as well”* (interviewee 2, p.9, line 13)

Both described the team's function in a similar way.

### **Implementing and using Care Aims**

Both AHP 1 and AHP 2 said that they felt using Care Aims was similar to how the team worked previously. Only AHP 2 described the formal training but both described how the team had thought about and adapted Care Aims for use within the team.

AHP 1 focussed particularly on how Care Aims was used to set goals and how it had helped the team to focus and think more about function rather than impairment. AHP 1 described how the team had worked together to set goals differently and that it had helped them clarify and manage expectations with patients.

AHP 1 described how challenging parts of the training had been particularly when thinking about her own caseload and identifying patients who potentially should not be on the caseload. Another challenge described was maintaining use of Care Aims when the service specification had changed and demand for the service increased. Care Aims was described as being used to inform triage but the Care Aims documentation was not as it was felt the team needed additional information to inform decision making. AHP 1 described how the team used supervision and development workshops to explore how Care Aims was and could be used within the team.

AHP 2 described the impact of the formal Care Aims training for herself using phrases like "*penny dropping*" (interview 2, p. 2, line 23) and "*waves of almost like adrenaline*" (interview 2, p.2, line 24). AHP 2 also described how Care Aims had helped clarify expectations of patients and also for staff in terms of their role and duty of care. AHP 2 identified one of the challenges implementing Care Aims as being able to train new people who started work with the team after the formal training had been completed. Whilst the team has an informal programme, interviewee 2 felt it did not inspire new staff in the same way and their understanding of Care Aims was less than those who had completed the formal training.

Similar to AHP 1, AHP 2 described the professional dilemma of whether somebody should be on the caseload. The dilemma was different in that the issue was whose benefit goals were being set for: patient or family/carer. Whereas for AHP 1 it was the conundrum of very dependent disabled patients receiving less intervention than more able patients. Historically the most disabled patients would have received the most treatment irrespective of the change in impact of their disability on them. With the introduction of Care Aims impact became more significant. If a patient's level of ability

had changed very little and the impact of their condition was perceived to be low they would now receive very little if any intervention. A more able patient who had previously been fit and well but for whom the impact of their condition was greater would now receive more intervention. For AHP's the dilemma was whether intervention was being sought to improve things for the patient or because carers wanted and/or expected intervention. AHP 2 also described how Care Aims could present cultural challenges in terms of expectations of health professional's interventions and the role of the patient in participating in therapy.

Both AHP 1 and AHP 2 described the benefits of integrated goal setting for the rehabilitation assistants and that had made their roles more manageable and that they were able to see more clearly why rehabilitation programmes were structured in a particular way. Both were also able to give examples of when they had used Care Aims with positive outcomes and indicated that the team would continue to use the Care Aims approach.

#### **6.7.4 Results from the Patient Responses to the Care Aims Questionnaires**

The patient response was completed by the patient's carer. The role of the team was described as helping with rehabilitation to become more independent and to improve quality of life. The team was described as multi-disciplinary and consisting of physiotherapist, occupational therapist, speech and language therapist, nurse, consultant and the GP.

The team were described by Patient 1 as being excellent "*no matter what problem*" they had had (question 4), particularly the nursing staff who continued to help although they were not directly involved with the patient anymore. They felt that care was effective because it was reassuring, reliable, gave them peace of mind and friendship (question 5).

The questions that asked for a less positive or less helpful situation or event were left unanswered.

The carer was able to clearly described what they hoped would happen as a result of assessment by the team. When asked how they felt about that now they responded "*very good – as well as can be expected*" (question 11).

### **6.7.5 Results from the Patient Interview to the Care Aims Questionnaires**

At the interview both the patient and their main carer were present. Although the patient had difficulty verbally expressing himself he was able to consent to participating and using non-verbal communication indicated he understood the questions and whether he agreed with the response his carer gave.

The interviewees identified that they had been involved with a range of health and social care professionals including those from the team involved in this study. The carer described how the patient had presented initially and the progress made over time. The carer described the specific goals that were personal to them that they had worked on with the team but suggested that it was the teams plan: "*they had a different plan, sort of stages*" (p.4, line 4). They indicated they were happy with the plan and they had achieved "*everything they had wanted to achieve*" (p.9, line 13).

The carer said that although their care from the team had finished they could ring up any time for advice and were continuing to work on specific aspects of rehabilitation.

### **6.7.6 Developing the Thematic Network**

Similar to the previous case studies the data was analysed using the approach described in section 4.12. From the team and patient questionnaires and interviews a thematic network was constructed with three global themes identified (table 6.10, p.146).

Table 6.10 Themes generated from case study 3

| Basic theme  | Organising theme                      | Global theme               |
|--|---------------------------------------|----------------------------|
| 1. Training motivates implementation                 | 1. Training is important              | 1. Change process          |
| 2. Varied understanding of Care Aims                 |                                       |                            |
| 3. Different opportunities                           |                                       |                            |
| 4. Implementation required little change             | 2. Using Care Aims was natural        |                            |
| 5. Adopting Care Aims                                | 3. Conflicting priorities             |                            |
| 6. Influence of capacity and demand                  |                                       |                            |
| 7. Prioritising patients                             |                                       |                            |
| 8. Conflicting provider and commissioning priorities |                                       |                            |
| 9. Exposing commissioning gaps                       |                                       |                            |
| 10. Not feeling supported                            | 4. Challenging professional cultures  |                            |
| 11. Exposing professional cultural differences       |                                       |                            |
| 12. Altered self-perception                          |                                       |                            |
| 13. Challenge of training                            |                                       |                            |
| 14. Functional goal setting challenges               | 5. Managed implementation             |                            |
| 15. Adapting the paperwork                           |                                       |                            |
| 16. Planning implementation                          | 6. Integrated team working is natural | 2. Team culture            |
| 17. Understanding scope of practice                  |                                       |                            |
| 18. Patients' perception of integration              |                                       |                            |
| 19. Integrated team working                          |                                       |                            |
| 20. Feeling comfortable                              |                                       |                            |
| 21. Hierarchical working                             | 7. Influence of hierarchy             |                            |
| 22. Following Care Aims                              |                                       |                            |
| 23. Facilitating integrated working                  |                                       |                            |
| 24. Increasing understanding                         | 8. Functional goal setting integral   |                            |
| 25. Focus on impact                                  |                                       |                            |
| 26. Managing expectations                            |                                       |                            |
| 27. Active patient role                              |                                       |                            |
| 28. Professional connections                         | 9. Integrated AHP working             |                            |
| 29. AHPs integrated working                          |                                       |                            |
| 30. Different practices                              |                                       |                            |
| 31. Differing goals                                  | 10. Patient centredness               | 3. Care Aims as an enabler |
| 32. Personal patient goals                           |                                       |                            |
| 33. Positive patient experience                      |                                       |                            |
| 34. Goal attainment                                  |                                       |                            |
| 35. A patient centred approach                       | 11. Facilitating decision making      |                            |
| 36. Identifying priorities                           |                                       |                            |
| 37. Facilitating clinical reasoning                  |                                       |                            |
| 38. Influencing triage                               |                                       |                            |

### **6.7.7 Theme 1: Change Process**

Similar to the case studies 1 and 2, the first thematic network explores the change process (figure 6.14, p.148). However the basic and organising themes differ and present a different narrative.

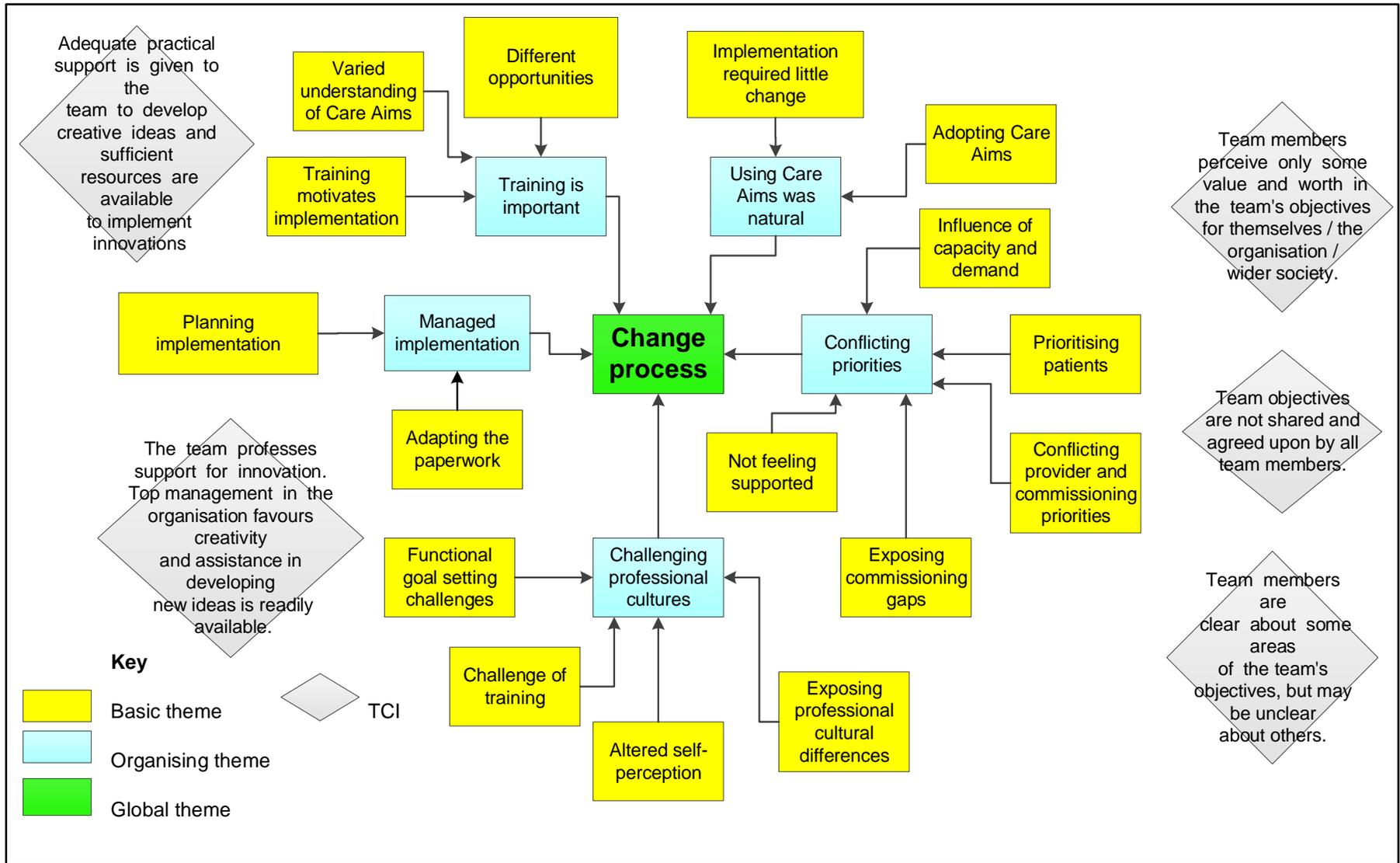


Figure 6.14 Case Study 3: Theme 1 – Change process

Care Aims was described as being similar to how the team worked prior to its implementation suggesting that the team was not required to change much. AHP 1 said that implementing Care Aims “*wasn't that much of a culture shift*” (AHP 1, p.11, line 7) (basic theme 4, table 6.10, p.146) with responses suggesting that Care Aims was used by the whole team. However whilst the majority of the team identified that they used Care Aims for their whole caseload several (AHP 2, AHP 7 and AHP 8) indicated that this was not the case across the whole team.

Whilst the team was keen to use Care Aims there were conflicting priorities, expressing frustration at being asked to prioritise patients who scored low on clinical need. AHP 8 said about Care Aims:

*“it was helpful to guide the team as pressures from the commissioners often try to guide the service in a way that doesn't relate to their clinical need”*  
(Team questionnaire 10, question 7) (basic theme 8, table 6.10, p.146).

For example team members described how the team's service specification had changed and the team were asked to see a cohort of patients where quicker turnaround was required. AHP 3 said:

*“clinical risk scores appear irrelevant, all our patients get seen in date order ...patients who would probably score less get seen first so jump the queue”*  
(Team questionnaire 2, question 9) (basic theme 7, table 6.10, p.146).

AHP 2 identified that with the increasing speed of turnover using Care Aims at the triage stage had “been lost” (AHP 2, p.12, line 1) but did feel it was of value when there were two referrals competing for the same assessment slot and being able to identify which should take priority. AHP 1 thought that for some patients using the documentation “*became unmanageable and meaningless*” (AHP 1, question 9) (basic theme 6, table 6.10, p.146).

In another example AHP 2 described a scenario of utilising the Care Aims approach to respond to a complaint and feeling able to clearly articulate why the patient had been seen and when. AHP 2 considered the patient to be a lower priority than another patient who had been referred earlier but was seen after the other patient. However they were overruled by the manager; AHP 2 surmising the manager wanted to prevent the complaint escalating.

Team members suggested that Care Aims exposed gaps in commissioned services with AHP 1 saying:

*“...there’s nowhere else for them to go. They do need therapy but not necessarily with a specialist integrated team”* (AHP 1, p.8, line 11-12) (basic theme 9, table 6.10, p.146).

Both AHP 1 and AHP 2 stated they did not use the pre-referral elements of Care Aims as they were not commissioned to do that and their criteria were from the point of referral and were disappointed about this.

The conflicting priorities theme is supported by the TCI which suggested that team members were clear about some areas of the team’s objectives but may be more unclear about others. The TCI also suggested that team members perceived only some worth in their objectives for the organisation and that the team’s objectives were not shared or agreed upon by all team members.

Two of the four respondents to the OCAI identified the market culture as the current dominant culture possibly a reflection of the changes to their service specification and the increased demands on the team. The market culture was not identified as the preferred culture for any of the four respondents to the OCAI.

Weiner (2009) describes organisational readiness for change as a *“multi-level construct”* (p.2) that is present at individual, group, department or organisational level. Whilst it would appear that the team were ready to implement the change, those around them may not have been e.g. the manager was perceived to prioritise de-escalating a complaint over Care Aims implementation. The team’s readiness for change may have been facilitated by the perception of team members that Care Aims was not that different from how they currently worked implying the motivation to change (unfreezing) was minimal.

The team described how the Care Aims training had prompted them to reflect on the differences between professions e.g. when setting goals and that the teams thinking was more closely aligned to Care Aims which made it easier for them to grasp the Care Aims approach. AHP 1 also commented that the training reinforced their view that they were *“actually quite on the right lines really”* (AHP 1, p. 3, line 15) (basic theme 1, table 6.10, p.146).

The majority of team members described attending the Care Aims training although interpretation of Care Aims appeared to vary within the team. Those who attended the formal training appear to have a more consistent understanding of Care Aims: collaborative goal setting with patients, a framework to support clinical decision making.

Those who joined the team later (AHP 3, AHP 6 and AHP 9) identifying that Care Aims was already in place when they started working with the team appear to have a more limited understanding, describing Care Aims as:

*“another form of SMART goals”* (Team questionnaire 2, question 4) (basic theme 3, table 6.10, p.146).

*“a framework for managing caseload”* (Team questionnaire 8, question 4) (basic theme 3, table 6.10, p.146).

This was recognised by AHP 2 who expressed disappointment that new members of the team did not have the same opportunity to attend the formal training and described:

*“having to kind of convince them whereas you want them to have those penny dropping moments for themselves because that was the thing that I think for quite a few of us made, had such a big clinical impact”* (AHP 2, p.4, line 1) (basic theme 1, table 6.10, p.146).

This suggests the importance of training to facilitate understanding of Care Aims. As RA 3 said:

*“I was not sure why I was there because I would not be writing Care Aims but it has given me a better understanding of them”* (Team questionnaire 5, question 4) (basic theme 1, table 6.10, p.146).

The training itself motivated staff to implement Care Aims. AHP 2 felt inspired and empowered:

*“I could make something change from that point....And that was really exhilarating because you don’t often come away from a course with that”* (AHP 2, p.2, line 25) (basic theme 1, table 6.10, p.146).

The team came away from the training and started to plan and facilitate the implementation of Care Aims. The importance of training identified by the team on implementation supports the work of Shortell et al (1998) who proposed that conditions for effective continuous quality improvement included the use of focussed interventions – in this case, Care Aims training. Formal training is one of the conditions that Schein (2010) recommends for creating sufficient psychological safety to outweigh the degree of learner anxiety for change to be successful.

Several team members described developing the paperwork following the training to meet team needs. AHP 7 recalled that permission had been gained to make the paperwork suitable for a multidisciplinary team. Others described practicing setting

functional goals and AHP 2 identified that they were a Care Aims champion. Ownership of the implementation process was alluded to by several respondents (AHP 2, AHP 7 and AHP 8) who were not all in leadership roles:

*“The team then took the Care Aims approach and integrated into our ways of goal setting”* (Team questionnaire 10, question 5) (basic theme 16, table 6.10, p.146)

*“Team has workshop to discuss and plan how Care Aims would be implemented in the team”* (Team questionnaire 9, question 5) (basic theme 16, table 6.10, p.146)

*“internal workshops regarding implementation for our team”* (team questionnaire 11, question 5) (basic theme 16, table 6.10, p.146).

Another example of how the team had adapted the paperwork was in relation to the triage process. AHP 8 described how they had changed the documentation several times and agreed as a team what needed changing and then implemented their agreed solution.

The TCI also supported the notion that the team was innovative and found time for developing new and improved ways of doing things e.g. implementing Care Aims. The OCAI partially supported the notion of a dominant innovative culture as the adhocracy culture scored very low for all four respondents as the current culture but for two of the respondents it was identified as their preferred culture.

Although the team appear to have implemented and adopted Care Aims it was not without team members experiencing a challenge to their professional cultures. AHP 1 described attending the training with staff from another profession (different from those in their team) and said:

*“I hadn’t realised the difference between how we set goals...I took it as the norm really, that’s what everyone was doing but on the course quickly learnt that obviously wasn’t the case”* (AHP 1, p.3, line 5) (basic theme 11, table 6.10, p.146).

Other team members described some of the personal challenges the training brought, particularly when thinking about impact. AHP 9 described the dilemma faced on deciding to discharge a patient:

*“the patient still had potential and could functionally improve – should we be discharging her”* (Team Questionnaire 12, Question 12) (basic theme 13, table 6.10, p.146).

AHP 2 described having to:

*“ignore the stuff that isn’t a concern to us on a clinical level... but for has for them no impact”* (Interviewee 2, p. 6, line 15) (basic theme 14, table 6.10, p.146).

And AHP 1 said:

*“I didn’t like it particularly because I was sort of thinking well I don’t like sort of saying yes you’re really dependent but actually the impact on your life isn’t that great so therefore you’re lower down the list than Joe Bloggs who actually on looking at him is very mild”* (AHP 1, p. 3, line 33) (basic theme 13, table 6.10, p.146).

AHP 2 described how she felt her thinking about her profession had evolved and was different from colleagues of the same profession in other organisations, particularly in terms of thinking functionally rather than from an impairment perspective. She had not realised this until meeting staff from the same professional from other organisations:

*“If I’ve gone to \_\_\_\_ meetings outside the organisation, says SIGS or something like that and I do feel a bit out there.”* (AHP 2, p.9, line 27) (basic theme 12, table 6.10, p.146).

In this team many of the eight conditions that Schein (2010) identifies as necessary for creating psychological safety appear to have been recognised if not all met.

### **6.7.8 Theme 2: Team Culture**

The second thematic network explores team culture (figure 6.15, p.154). The organising themes covering aspects of integrated working, hierarchical working and the importance of functional goal setting.

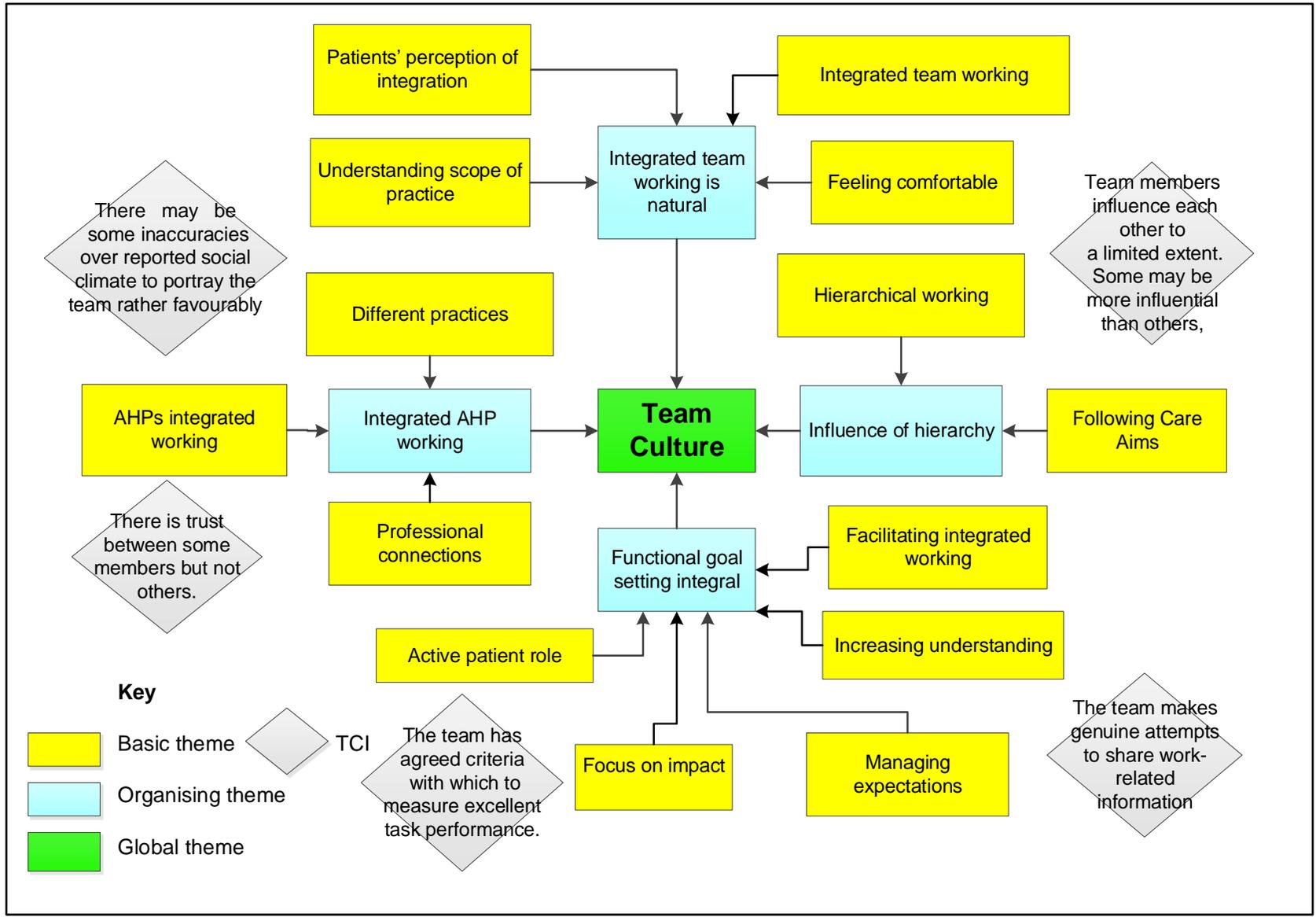


Figure 6.15 Case Study 3: Theme 2 - Team culture

As described previously the majority of respondents described the team as multidisciplinary. Four respondents (AHP 1, AHP 2, AHP 7, and AHP 8) described the team as interdisciplinary. Two of these were OTs. AHP 8 also describing the team as integrated. However many team members either directly described or alluded to how the team worked together to provide integrated care. AHP 1 recalling how the team were set up as an integrated team initially.

Team members appeared to be comfortable working as an integrated team with many responses giving examples of team members working together:

*“integrated therapy plans”* (Team questionnaire 1, question 6) (basic theme 20, table 6.10, p.146).

*“each therapist from each discipline involved attends the meeting and helps set the goal.”* (Team questionnaire 4, question 6) (basic theme 20, table 6.10, p.146).

*“patient, family and all the therapists understood the final goal and how we would achieve it”* (Team questionnaire 12, question 7) (basic theme 20, table 6.10, p.146).

AHPs and rehabilitation assistants all described how the functional goals had made it easier for the rehabilitation assistants to work in an integrated way as the goals made more sense. AHP 2 described the rehabilitation assistants as the:

*“lynch pin that pull it all together”* (AHP 2, p.9, line 11) (basic theme 23, table 6.10, p.146)

and said:

*“it makes their job a darn site easier in not having to remember what goals are from each of the three disciplines or what or four if there’s something that involves the psychology aspect”* (AHP 2, p.9, line 11) (basic theme 23, table 6.10, p.146).

AHP 2 felt that the rehabilitation assistants did not now need to think about whether their focus was OT, physiotherapy, SLT or psychology, they could just focus on the task in hand such as working in a kitchen baking and this would achieve all. This also demonstrated how setting functional goals facilitated integrated working. AHP 2 went onto describe how they now took the patient’s goal and used that to map therapy onto:

*“Their goal might be to get back into baking...but I also want to be working on my walking and balance... I also want to work on following a recipe and being able to read and speech is still important so then you take that vehicle for your therapy and then just map everything on underneath”* (AHP 2, p. 9, line 22) (basic theme 23, table 6.10, p.146).

The very nature of a functional goal appears to facilitate a more integrated approach to care as few functional activities can be performed in relation to one profession only. The use of functional goals in facilitating improved integrated team working also appears to support the finding of Cameron et al (2012) who suggest that one way of reconciling professional values and roles with the aims and objectives of the team is to ensure that the outcomes for service users and carers are “made explicit from the start so practitioners can appreciate the benefits of the joint activity they support” (p.17).

The team also perceive that patients think they work in an integrated way. AHP 1 illustrated this:

*“I think they understand that we’re different but I also think they understand they don’t necessarily have to wait for somebody else to come out. They can talk to you about it because you may be able to give them some ideas”* (AHP 1, p. 8, line 8) (basic theme 18, table 6.10, p.146).

The TCI identified that the team made:

*“genuine attempts to share work related information. Individuals pass on information extensively and regularly”* (TCI report for case study 3, page 3, line 16)

This would appear to support the belief that the team work in an integrated way. Team members described how they had received additional training to support them working in a more integrated way which had enabled them to develop new skills outside their traditional scope of practice. They were also aware of those activities that were outside their scope of practice and gave examples of when to ask for help. There appeared to be collaboration and respect between the different AHPs. AHP 1 highlights differences in professional culture without being dismissive of another profession described how as an OT, physiotherapy activities were easier to manage and that speech and language therapy was harder *“because I can’t see it necessarily”* (AHP 1, p.7, line 30).

Whilst there were examples given of OTs, physiotherapists and SLTs working together, psychology was rarely mentioned. Team members when talking about the team used the term therapists with psychology not mentioned in any of the questionnaire responses. Psychology was only mentioned once in each of the interviews with AHP 1 and AHP 2. There were also no questionnaire responses received from psychologists. Peck and Norman (1999) in their study exploring inter-professional role relations in a community mental health team suggested that psychologists perceived themselves as *“relatively free-floating, high status mental health workers”* (p.242) and

*“although committed to multi-professional working they are ambivalent about being too closely identified with teams” (p.242).*

In this team, this may be further reinforced by the leadership team consisting of an OT, physiotherapist and SLT.

The TCI also suggested that some team members may be more influential than others which may support the lack of visible psychology team members. The TCI also noted that there may be trust between some team members but not others again potentially supporting the strong working relationship between occupational therapy, physiotherapy and speech and language therapy but not psychology. This may also reflect the influence of the leadership team which consists of an occupational therapist, physiotherapist and speech and language therapist. The importance of leadership in an integrated team is well documented (Williams, 2012; Howarth et al, 2006; Belling et al, 2011; Boon and Kachan, 2008; and West et al, 2012). The NHS Confederation (2006) summarising the evidence base for integrated care identify the need for professional leadership. In this case study, by having three team leaders from each of three allied health professions in the team, professional leadership is inherently provided to those professions but absent for the psychology profession. This may be perceived as an unequal power distribution which may impact on how psychologists participate in the team.

Similar to power, hierarchy can influence team functioning as appears to be demonstrated in this case study. Team functioning appearing to suggest a sub-culture based on rank and status although this may be about more senior staff wanting to protect other staff suggested by use of the word ‘fair’. This may also be a reflection of the team having three senior clinicians leading the team as clinical team leaders rather than one team leader aligned to one profession. One of the leads explaining why band 6 staff did not triage said:

*“we didn’t think it was fair for them to be making that decision sort of over the phone so that’s why we decided the band 7’s would do all the triage” (AHP 1, p.10, line 13) (basic theme 21, table 6.10, p.146).*

Whilst the rehabilitation assistant’s responses suggested support for the Care Aims approach responses also suggested that they felt it was primarily for qualified staff:

*“I do not complete Care Aims but follow them” (Team questionnaire 3, question 10) (basic theme 22, table 6.10, p.146).*

*“my role is not to write Care Aim goals and approaches. They are used by qualified therapists”* (Team questionnaire 4, question 10) (basic theme 22, table 6.10, p.146).

The OCAI results showed no one preference for either the current or preferred culture. The examples given of the team working together to implement Care Aims, setting functional goals with patients, possible protective attitude by senior staff could be suggestive of a dominant clan culture. The need for a process and Care Aims documentation through continuous incremental quality improvement could suggest a dominant hierarchy culture (Cameron and Quinn, 1999).

The responses indicated that the AHPS worked in an integrated way and examples were given of functional goal setting that integrated occupational therapy, physiotherapy and speech and language therapy. It was suggested that thinking functionally rather than from an impairment perspective e.g. a patient who wanted to be able to prepare a meal for themselves had facilitated this. AHP 1 said:

*“now we’re sort of better at writing those broader functional sort of goals rather than just thinking about me with me OT head on”* (AHP 1, p.4, line 19) (basic theme 24, table 6.10, p.146).

One of the facilitators and barriers to integrated team working commonly cited in the literature is clarity of role and responsibilities (Cameron et al, 2012; Cameron and Lart, 2003; Maslin-Prothero and Bennion, 2010). Team members consistently described clarity about roles and responsibilities particularly through the goal setting process. This included team members from all grades. RA 1 said:

*“me as a rehab assistant and therapist and patient/carers know exactly what is going on”* (Team questionnaire 3, question 7) (basic theme 26, table 6.10, p.146)

And RA 2:

*“everyone involved in the rehab programme understands their role”* (team questionnaire 4, question 7) (basic theme 26, table 6.10, p.146).

This was supported by the TCI results as mentioned previously regarding the extensive sharing of information and also that the team has agreed criteria to measure excellent task performance i.e. they know what good looks like. Whilst the team frequently described joint goal planning, this was only partly supported by the patient carer who said *“they had a plan”* (Patient interview, page 2, line 23) (basic theme 26, table 6.10, p.146)

but then who later describes functional activities tied to key events that the treatment plan and goals were linked to e.g. mobile in a wheelchair and able to eat Christmas dinner in the dining room at home.

Both team members and the patient carer talked of patients and team members as equals for example when it came to decision making. One team member gave an example:

*“The patient decided she did not have any further goals despite having potential. A goal meeting with the family carer and social worker along with the patient and the team allowed us all to agree discharge”* (Team questionnaire 12, question 10) (basic theme 27, table 6.10, p.146).

Also suggestive of the perception of a dominant clan culture was the experience of the patient carer who described how they felt they were part of the team too and said of the team:

*“They’re a family. They’re friends”* (Patient interview 1, page 8, line 4) (basic theme 27, table 6.10, p.146).

The use of functional goal setting and other team processes ensured that the team had clearly defined processes to support integrated working. By focussing on function rather than impairment and using impact to facilitate patients to identify their priorities for intervention, the patient was kept at the centre of care provided and holistic approach was taken. These are acknowledged as key elements of providing integrated care (Kodner and Spreeuwenberg, 2002; Shaw et al, 2011).

### **6.7.9 Theme 3: Care Aims as an Enabler**

The thematic network for the third theme for Case Study 3 explores Care Aims as an enabler (figure 6.16, p.160). The organising themes identifying the perception of Care Aims enabling a person centred approach and facilitating decision making.

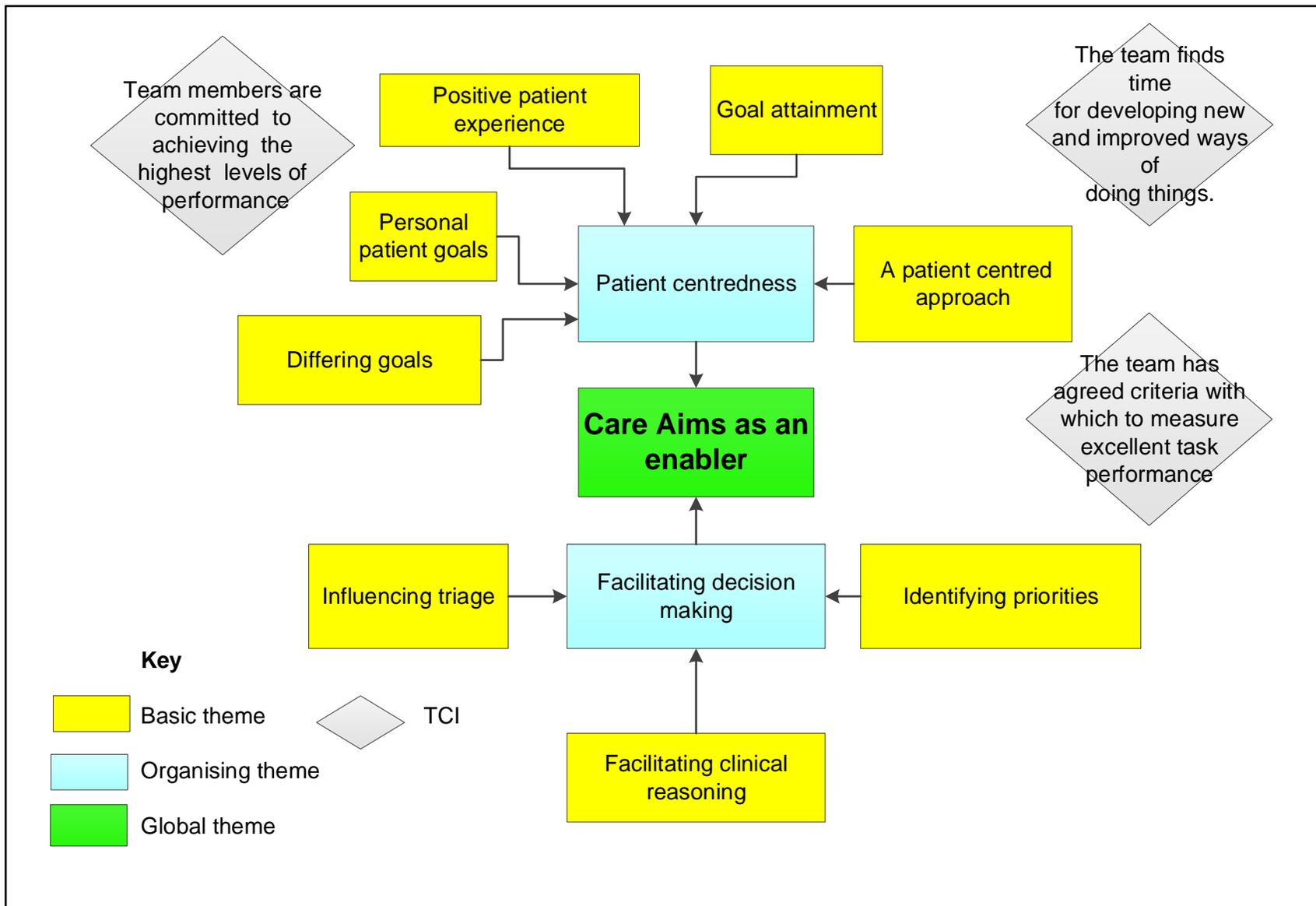


Figure 6.16 Case Study 3: Theme 3 - Care Aims as an enabler

Whilst the team felt that they had not had to change much to implement Care Aims, it was felt that Care Aims had positively influenced how they provided care, particularly in the context of goal setting and providing clarity about where and how they could be most effective and it facilitated them to be more patient centred. AHP 2 said:

*“I think previously the goals were coming from us. We would guide the patient much more....whereas I think that with that, from the Care Aims I think it rang bells with us all to the point where I think completely embraced that patient centredness”* (AHP 2, page 3, line 1) (basic theme 35, table 6.10, p.146).

This appears to support the notion proposed by Meyer (2009) building on previous work by Herscovitch and Meyer (2002) that when the commitment to change is based on valuing the change i.e. staff want to change rather than need to change, this better supports readiness to change and more successful implementation.

The use of functional goal setting was seen as a foundation for this. AHP 2 described a time when as a team they had set with a patient functional goals related to his pet as this was having a significant impact on his life in terms of his general mental health as a result of his primary physical condition. She noted the carry over into other areas of therapy as a result of achieving this goal and went on to describe how previously setting that type of goal would have not sat comfortably but now it did:

*“I think years ago that would have felt absolutely bizarre and almost unmeasurable in some ways.... It felt very robust”* (AHP 2, page 7, line 5) (basic theme 32, table 6.10, p.146).

This example suggests that AHP 2 has the confidence and competence that Barrett et al (2005) identified as crucial to interprofessional working. The patient carer interviewed also described personal functional goals that had been achieved and the positive impact that these had:

*“you know it’s just that little bit of independence he’s got now”* (page 5, line 25) (basic theme 33, table 6.10, p.146)

and

*“the best things were when they got him to sit up and to go into the electric chair...and now he can go, not on his own but if he wanted he can go out under his own power”* (page 5, line 7) (basic theme 33, table 6.10, p.146).

AHP 1 felt that using functional goals had also facilitated the team to focus although not changing the therapy they would do. She commented that this had not improved outcomes but had helped manage patient expectation:

*“I think it’s their change of mindset... so I don’t necessarily think it’s changed the outcomes of rehab. I think it’s maybe changed their focus on what they think they can achieve in a certain time”* (AHP 1, page 4, line 34) (basic theme 36, table 6.10, p.146).

This is supportive of previous research which found a patient centred approach led to improved engagement, reduced anxiety; better compliance (Bensberg, 2007) although in a study by Leach et al (2010) therapists commented that patients often put forward goals that the therapist considered unachievable or unrealistic at that stage of rehabilitation. The study by Leach et al (2010) was in a similar rehabilitation phase to the patients seen in case study 2 – subacute. Of the eight therapists interviewed only one was identified as using a patient centred approach rather than therapist led or therapist controlled.

As described in case study 2 there is limited research relating to integrated care involving the voice of service users and carers. However Cameron et al (2012) identified that service users valued interventions tailored to their individual needs and a more holistic approach. The team explained that the Care Aims training had helped them move from impairment led goals to more functional goals. Leach et al (2010) stated that therapists reported that patients identified improvement in specific functions when asked to identify goals suggesting that a functional approach to goal setting is more patient friendly and enables patients to engage thus facilitating a patient-centred approach. Several of the team identified that setting functional goals and sub-goals helped patients decide what was realistic, better manage expectations and better understand the purpose of therapy as it was presented in the context of their life. AHP 9 said:

*“the patient could see the steps that he needed to achieve... and understood that he needed to progress through these steps in order to achieve the final goal”* (Team questionnaire 12, question 7) (basic theme 34, table 6.10, p.146).

Whilst this was felt to be generally beneficial it was not without challenge, particularly when linking physical and cognitive aspects of rehabilitation and that at times staff had to be ‘creative’ to do this. There were also challenges when patients and their families may not agree. AHP 2 said:

*"I'm not really sure what the goal is because I'm not really sure whether the goal is nothing to do with the lady and actually to do with the daughters"* (AHP 2, p.4, line 20) (basic theme 31, table 6.10, p.146).

For the team a patient centred approach was not just about participation in decision making such as goal setting but also included an expectation that patients would actively participate in the intervention to achieve goals. AHP 1 said:

*"if they don't participate they won't achieve their goals"* (Team questionnaire 2, question 7) (basic theme 34, table 6.10, p.146).

Care Aims was felt to have facilitated clinical decision making and clinical reasoning with team members. This was felt to be mainly due to thinking about the impact of a patient's presentation and their reason for intervening and providing a focus for therapy. Care Aims was also felt to enable reflection.

AHP 1 said:

*"It helps you assess with the patient how their disability actually impacts on their life as opposed to what their disability is"* (Team questionnaire 1, question 11) (basic theme 36, table 6.10, p.146).

Functional goal setting as a result of using Care Aims was also felt to be of benefit for the team, particularly for the rehabilitation assistants. Responses from the rehabilitation assistants themselves included:

*"I know exactly what needs focussing on"* (Team questionnaire 3, question 6) (basic theme 36, table 6.10, p.146)

*"I think Care Aims allows patients to set their own realistic goal. Reading a Care Aims programme is very easy to follow"* (Team questionnaire 4, question 11) (basic theme 36, table 6.10, p.146)

*"It enables everyone to work together and know what we are working on"* (Team questionnaire 5, question 4) (basic theme 36, table 6.10, p.146).

This was also supported by both AHP 1 and AHP 2. AHP 1 gave the following example:

*"Before we'd say to them we want you to do visual processing stuff for 4 weeks and they'd be like really? Thinking that's like just boring but I think now they still do that but then they can see how it goes into functional and why they need to do it"* (AHP 1, page 5, line 29) (basic theme 36, table 6.10, p.146).

Examples were given of how Care Aims had helped the team focus what they spend their time on and how they prioritise. One example was in relation to new referrals and being clearer with referrers about what decision was being made and why. AHP 2 said that as a result of using Care Aims they felt they were now *“a clearer decision maker”* (AHP 2, page2, line 17) (basic theme 37, table 6.10, p.146).

Similar to previous findings (Maslin-Prothero and Bennion, 2010; Cameron et al, 2012) clarity of roles and responsibilities, a patient-centred approach supported integrated team working. Care Aims was seen by the team as an enabler as to how they wanted to work. The team were able to articulate many positive outcomes as a result of implementing Care Aims. Schein (2010) notes that the new cultural elements, in this case, adoption of the Care Aims approach:

*“ can only be learned if the new behaviour leads to success and satisfaction”*  
(p.312).

#### **6.7.10 Case Study 3 Summary**

In this case study three thematic networks were explored for the global themes of change process, team culture and Care Aims as an enabler.

The global themes in this case study suggest that Care Aims has been successfully implemented and that implementation has facilitated a more integrated approach to care. Implementation has not been without challenges but the team appears to have overcome these. Central to this appears to have been the receptive context and readiness of the team and the presence of facilitators to integrated team working such as a patient centred approach, role clarity, processes such as functional goal setting.

Whilst functional goal setting appears significant in facilitating the team to work in an integrated way, the examples given by respondents all related to AHP activities. Although a culture of collaboration and respect appears to exist between allied health professionals there appears to be less evidence to support this between AHPs and psychologists.

Little change appeared to be required from the team in order to implement change. However the presence of three AHPs in the leadership team and a Care Aims champion within the team may also be critical factors to the apparent successful implementation.

## **6.8 CASE STUDY 4**

This section reports and analyses the findings for Case Study 4.

### **6.8.1 Response Rates**

There was only one response to the Team Care Aims questionnaire and no team members volunteered to participate in an interview. No patient questionnaires were returned and therefore no patient interviews took place.

### **6.8.2 Results from Team Care Aims Questionnaires**

#### **Respondent**

The respondent had worked with the team for more than 2 years and was band 7 or above. They had a leadership role within the team and were an AHP.

#### **Perception of team type, role and function**

The respondent described the team as integrated/multidisciplinary. The role of the team was described as preventing admission to hospital with multidisciplinary interventions.

#### **Implementing and using Care Aims**

The respondent did not answer the question asking for a description of Care Aims in their own words.

Care Aims was reported as being used initially for triage to support decision making about a referral. The respondent reported that Care Aims was more difficult to implement into day to day practice due to the *“fast nature of the service”* (team questionnaire 1, question 5).

Care Aims was reported to be helpful in supporting decisions particularly when deciding to decline a referral e.g. if a patient had previously had several episodes of care with the service or had needs that could not be met by the service.

The respondent reported that it was difficult to identify the benefits of Care Aims during interventions again due to the fast pace of the service.

The respondent noted that they only use Care Aims when triaging referrals and that it helped promote a good outcome for the referrer and patient.

### **6.8.3 Analysis and Discussion**

A thematic network was not developed due to the lack of data. From the data it would appear that Care Aims is being used purely in triage to support decision making as to whether or not to accept a referral. The respondent used the term 'fast/rapid' more than once in their response suggesting the focus of the team is on pace which is consistent with the perception of a market culture where the emphasis is results orientated and about 'getting the job done'.

The lack of a response to the question asking the respondent to identify Care Aims in their own words and the later response suggesting that it would be difficult to see how Care Aims could be utilised in the team could suggest that the respondent had limited understanding of Care Aims. The respondent neither identified attending any training which may explain the potential lack of understanding.

Gray et al (2001) and Harrison (2005) identified time constraints, team motivation and research not being seen as part of their role as barriers to healthcare staff participating in research. This is further supported by Pager et al (2012) who explored the motivators, enablers and barriers to building research capacity in the allied health professions. Pager et al (2012) also found that AHPs were motivated to participate in research when they felt it would ensure best practice and improve outcomes for their patients. Questionnaires of interest to the respondent are shown to have a higher response rate (Edwards et al, 2002) than when the value of the questionnaire is not clear or perceived to be low (Van Geest et al, 2007). It is possible that in this team both lack of time and Care Aims not being valued by the service negatively impacted on the response rate. An alternative theory relating the perceived dominant market culture is that the questionnaire was not perceived to add value to how the team achieves its targets and the priority would have been achievement of tasks that are directly patient related rather than a questionnaire. Whereas if the team had had a stronger adhocracy culture and innovation had a greater emphasis, there may have been a better response rate. Responses included:

*"Due to the fast nature of the service it was more difficult to implement into day to day practice (team questionnaire 1, question 2)*

*“Difficult to identify the benefits of the approach for the team during interventions due to the fast pace of the service”* (team questionnaire 1, question 8).

This apparently negative response is then later contradicted and Care Aims is described as a really useful approach but this is in relation to screening referrals. This suggests that elements of Care Aims are being used rather than as an approach, similar in some respects to case study 2. The lack of a response to the question asking the respondent to describe Care Aims in their own words also suggests a lack of understanding.

It is possible that potential respondents were concerned about the confidentiality of the results as this has also been shown to negatively influence response rates (Van Geest et al, 2007). Unlike the teams in case studies 1, 2 and 3, the team in case study 4 had very little contact with the researcher prior to the study and they may have been concerned about how the data would be used or perceived given the researcher's senior role in the organisation.

The current dominant market culture appears to have influenced how Care Aims was used within the team. The team appear to have prioritised using those aspects of Care Aims that can help manage throughput such as triage and screening referrals rather than joint goal setting and focussing on impact thus helping the team complete their tasks and meet goals such as waiting times and preventing admission to hospital.

### **6.8.3 Case Study 4 Summary**

Due to the poor response rate and limited information on the team questionnaire the results and analysis should be viewed with caution. There are several factors that may have affected the response rate. It was felt important to include this case study despite the poor response rate to give a complete account of the data collection.

## CHAPTER 7

### INTEGRATED TEAM WORKING: COMPARATIVE ANALYSIS OF THE CASE STUDY THEMES

#### 7.1 Introduction

Chapter 6 presented the analysis of the individual case studies. Whilst there were some similarities in the thematic networks there were also significant differences. This chapter explores the similarities and differences that relate to integrated team working between the individual case studies. Chapter 8 explores those that relate specifically to Care Aims and its implementation.

#### 7.2 Process

Initially it was planned to use Leutz's Laws (Leutz, 1999; Leutz 2005) as the primary framework for the cross case analysis. In the literature review (chapter 2) whilst Leutz's laws were acknowledged to have no scientific basis they are widely recognised as principles for successful integration of care provision, supported by much of the literature (table 2.4, p.31) and described by Goodwin (2011) as "*enduring truths*". There is also an example in the literature where Leutz's laws have been used to analyse an individual case study (Tucker, 2010) although they are more widely used to explore and support theory and policy (Goodwin, 2011; Health Policy Insight, 2010; Leutz, 2005).

However Leutz developed the laws mainly to address integrated working between health and social care and to inform the delivery of integrated care which may be a result of integrated team working (Leutz, 1999). Tucker (2012) identified that integrated care was more frequently found in health rather than health and social care services and frequently delivered by multidisciplinary teams. This is an exploratory study and using a deductive approach did not seem consistent with the research methodology. Using a pre-existing framework could also potentially lead to omissions in the cross case analysis. Therefore applying Leutz's laws to these case studies as the sole framework was felt inappropriate.

An alternative framework using the principles of good interdisciplinary working (Nancarrow et al, 2013) was also considered mainly as it had been developed with teams similar to the ones in this study. Nancarrow et al (2013) recruited staff from

eleven community rehabilitation and intermediate care services. Their teams contained allied health professionals and support workers and overall appeared to be providing similar types of services to the teams in this study. However using the principles developed by Nancarrow et al (2013) were discounted for similar reasons to those described for Leutz's laws i.e. this is an exploratory study and potential for missing new themes that are not captured by that framework.

A third approach considered was the comparative analysis of the thematic networks that emerged from the individual case studies. Change was a global theme common to three of the case studies and each had global themes related to culture albeit different aspects. However the first three case studies all appeared to also have unique themes including a Care Aims specific theme which chapter 8 explores. This approach was rejected as it was felt this may also lead to not all the data or emerging new themes being explored.

An alternative method of comparatively analysing the case studies was sought. Cross case synthesis is defined by Yin as:

*“a compiling of data for a multiple-case study, by examining the results for each individual case and then observing the pattern of results across the cases”* (Yin, 2014, p. 238).

Yin (2012) describes cross case synthesis where the findings from individual case studies are brought together as *“the most critical parts of a multiple-case study”* (p.158). Yin (2014) suggests that one way of organising data is to create word tables displaying the data from individual case studies according to different categories. Unlike the previous approach of comparing the thematic networks, this approach returns to the interview, questionnaire and documentary data for each case study and also includes the data collected from the managers. The case studies have been compared and contrasted and word tables developed. The word tables for each category are shown within the section discussing that category. The categories are shown in figure 7.1 (p.171). Whilst many of the categories identified were consistent with those identified previously in the literature, several categories that did not appear to have been explored in the literature also emerged.

One of objectives of the study at this stage was to compare and contrast the case studies in this study with other published case studies. This has proved challenging. Similar to the findings of Nancarrow et al (2013) many studies were found that lacked detail in terms of context, team roles and processes to enable comparisons to be

made. Also as previously identified in the literature review (chapter 2) AHPs are either few in number or not mentioned in many studies exploring integrated team working. Whilst comparative analysis with other case studies was not felt to be possible, the wider literature has been explored to examine the evidence supporting or contrasting with the categories identified for the cross case synthesis.

### **7.3 Categories Identified for the Cross-case Synthesis**

The categories identified and used are represented in figure 7.1 (p.171). Some of the peripheral categories are similar to those of Nancarrow et al (2013) and other studies identifying facilitators and barriers to integrated team working (Cameron et al, 2000; Larkin and Callaghan, 2005; RAND Europe and Ernst and Young, 2012) such as leadership, vision, professional culture, staff roles and responsibilities. There are also some additional factors identified such as management of change, team climate and service type. Whilst philosophy and approach to care is alluded to in the literature (Nancarrow et al, 2013; Cameron et al, 2000; Larkin and Callaghan, 2005; RAND Europe and Ernst and Young, 2012) it is not specifically identified or as a critical factor underpinning integrated team working.

Each of the categories is described in turn starting with the peripheral ones and finishing with the central category. The categories are considered to be interdependent hence the two way arrows. Each category also has an arrow to the central category philosophy and approach to care. This category was placed at the centre as it appeared to be influenced by and influence all the other categories.

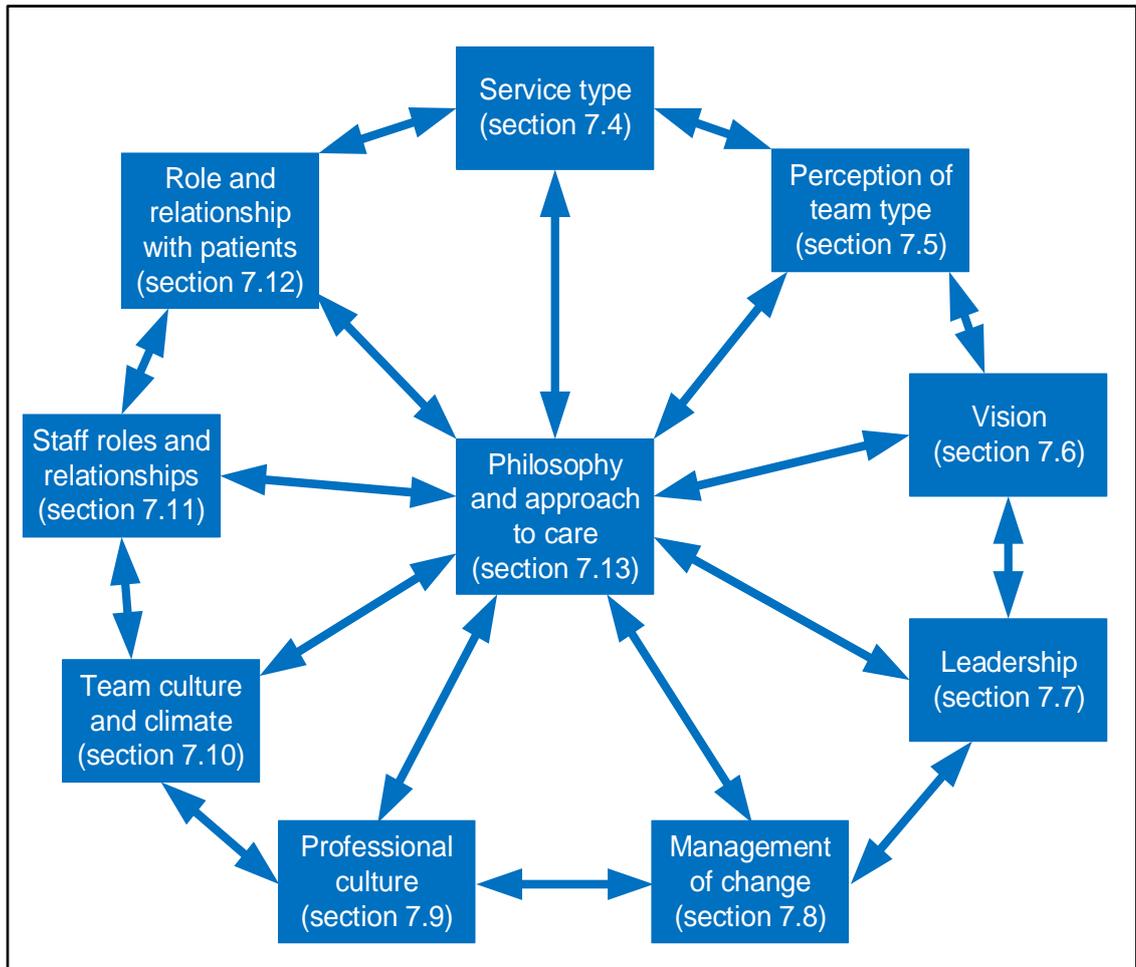


Figure 7.1 Categories that emerged in the cross case synthesis

#### 7.4 Service Type

All the teams in this study provided services that were targeted at specific populations and provided assessment and treatment. All the services were accessed by referral and referrals were triaged and prioritised by the team. Treatment in all teams was provided by a range of professionals who were managed by the same management team and with one budget for the whole team. The word table for this category is shown in table 7.1 (p.172).

Table 7.1 Service characteristics

| <b>Characteristic</b>                              | <b>Case study 1</b>  | <b>Case study 2</b>   | <b>Case study 3</b>   | <b>Case study 4</b>  |
|--|--|---|---|--|
| <b>Service type</b>                                | Provide specialist assessment and interventions for narrow range of long term conditions | Provide targeted assessment and interventions following specific trigger event(s)           | Provide targeted assessment and interventions following specific trigger event    | Provides targeted assessment and interventions in response to a trigger event    |
| <b>Population served</b>                           | Mainly elderly   | Mainly elderly  | Mainly elderly  | Mainly elderly   |
| <b>Where service delivered</b>                     | Community based  | Community based   | Community based   | Community based  |
| <b>Access to service</b>                           | By referral  | By referral   | By referral   | By referral  |
| <b>Referral process and prioritisation</b>         | Referrals triaged and prioritised by team  | Referrals triaged and prioritised by team   | Referrals triaged and prioritised by team   | Referrals triaged and prioritised by team  |
| <b>Type of intervention</b>                        | Usually shorter term interventions and may include provision of aids and equipment       | Interventions may be shorter or longer term and may include provision of aids and equipment | Interventions usually longer term and may include provision of aids and equipment | Interventions usually short term and may include provision of aids and equipment |
| <b>Link to hospital admission and/or discharge</b> | No   | Interventions may prevent admissions but this is not specific focus of service              | Referral usually follows hospital discharge                                       | Intervention is aimed at supporting early discharge or admission avoidance       |
| <b>Locality covered</b>                            | Covers two geographic localities   | Covers two geographic localities  | Covers two geographic localities  | Covers one geographic locality   |

The literature review referred to Leutz' laws of integration. The first law:

*“You can integrate all of the services for some of the people; some of the services for all of the people, but you can't integrate all of the services for all of the people”* (Leutz, 1999, p.83).

Leutz (1999) used this law to describe which people/client groups and where integrated care best applied to (table 7.2, p.173). The integration continuum is probably one of the most quoted aspects of Leutz integration work. In his review in 2005 Leutz reinforced

the need for there to be better recognition of the continuum that integration spanned and for integration efforts to be better tailored to the population they were aimed at.

Table 7.2 Integration Continuum (Leutz, 1999)

| <b>Operations</b>                    | <b>Linkage</b>  | <b>Co-ordination</b>   | <b>Full integration</b>  |
|--------------------------------------|---|--|--|
| <b>Screening</b>                     | Screen or survey population to identify emergent needs  | Screen flow at key points to find those who need special attention   | Not important except to receive good referrals                     |
| <b>Clinical practice</b>             | Understood and respond to special needs of people with disabilities in primary care, long term care, education etc. | Know about and use key workers to link                               | Multidisciplinary teams manage all care                            |
| <b>Transitions/ service delivery</b> | Refer and follow up   | Smooth the transitions between settings, coverage and responsibility | Control or directly provide care in all key settings               |
| <b>Information</b>                   | Provide when asked; ask when needed   | Define and provide items/reports routinely in both directions        | Use a common record as part of daily joint practice and management |
| <b>Case management</b>               | None  | Case managers and linkage staff                                      | Teams or 'super' case managers manage all care                     |
| <b>Finance</b>                       | Understand who pays for each service  | Decides who pays for what in specific cases and by guidelines        | Pool funds to purchase from both sides and new services            |

For each case study their caseload profiles have been mapped to the framework shown in table 2.2 (p.15). Case studies 1, 2, 3 and 4 all appear to sit between co-ordination and full integration. In Leutz's 1999 paper he describes several additional criteria to those in table 2.2 (p.15). These are screening, clinical practice, transitions/service delivery, information, case management and funding (table 7.2, p.173). This is possibly indicative that all the teams in this study had potential to be fully integrated.

Table 7.2 (p.173) also suggests that not all services that AHPs work in may be appropriate for full integration. Donnelly et al (2013) exploring the integration of OTs into Family Health Teams in Canada had similar findings. They found that the extent of OT integration into these teams was influenced by the nature of services provided. For

example integration was more likely to happen in more chronic and complex disease programmes such as diabetes and this would appear consistent with the framework in table 7.2 (p.173). They also identified that programmes such as these offered an opportunity to develop shared patient goals and shared vision of service delivery.

## 7.5 Team Type

In all the case studies teams were asked specifically to describe their perception of team type. The responses are shown in table 7.3 (p.174).

Table 7.3 Team reported team type characteristics

|                     | <b>Characteristics</b>  |
|---------------------|---|
| <b>Case study 1</b> | Team responses included multi-professional and multidisciplinary            |
| <b>Case study 2</b> | Team responses included interdisciplinary and multidisciplinary             |
| <b>Case study 3</b> | Team responses included multidisciplinary, interdisciplinary and integrated |
| <b>Case study 4</b> | Team responses included integrated and multidisciplinary                    |
| <b>Managers</b>     | Not applicable  |

Further analysis of the data exploring the more detailed responses about how the teams worked in practice and comparing them to definitions in the literature suggested different interpretations and naming conventions for team type (table 7.4, p.174).

Table 7.4 Suggested team type characteristics based on definitions in the literature

|                     | <b>Boon et al (2004)</b>             | <b>Thylefors et al (2005)</b>        |
|---------------------|--------------------------------------|--------------------------------------|
| <b>Case study 1</b> | Collaborative                        | Multi-professional                   |
| <b>Case study 2</b> | Coordinated                          | Multi-professional                   |
| <b>Case study 3</b> | Integrative                          | Transprofessional                    |
| <b>Case study 4</b> | Insufficient data to explore further | Insufficient data to explore further |
| <b>Managers</b>     | Not applicable                       | Not applicable                       |

Using the definitions of Boon et al (2004), case study 1 could be defined as collaborative i.e. practitioners practice independently from each other and collaborations are ad hoc and informed on a case by case basis and case study 3 integrative. Case study 2 could be defined as a coordinated team where members of the team are:

*“intentionally gathered together to provide treatment for a particular disease... and a case coordinator is responsible for ensuring that information is transferred between practitioners” (Boon et al, 2004, p.3).*

Tucker (2012) in an exploration of integrated care in community health services (including services similar to the ones in this study) in England and Ireland demonstrated that integrated care was being provided to service users of all ages with a wide range of conditions, illnesses and disabilities. Tucker (2012) found no evidence in her research of any patients being excluded from receiving integrated care on the basis of age, illness or disability. This may be due to Tucker’s recognition of the spectrum that integrated working covers as the majority of the teams in Tucker’s study providing integrated care were multi-disciplinary. However this would also suggest that all the teams in the current case studies have the potential to be integrated.

Using Thylefors et al (2005) definitions case studies 1 and 2 would be described as multiprofessional i.e.

*“a collaborative process where disciplines assess independently and only share information with each other” (p. 104).*

Case study 3 could be considered as transprofessional i.e. use an integrative work process and disciplinary boundaries are ‘dissolved’ (p.104).

Therefore it is possible at this stage to suggest that in order of most to least integrated, case study 3 provides the most integrated care, then case study 1 and least integrated being case study 2. This suggests that team working could be more influential on provision of integrated care rather than the patient’s illness or disability. This could suggest support for Donnelly et al (2013) who following their study exploring the integration of occupational therapists into primary care, proposed that Leutz’s first law (Leutz, 1999) also applied to healthcare professionals and aspects of their work: similar to not all services and people being appropriate for integration, not all aspects of an Occupational Therapists work were either e.g. some parts may be more individual or consultative. Adding to Leutz’s five laws of integration, an additional sixth law to be explored could be:

*“You can integrate all of the **teams** for some of the people, some of the **teams** for all of the people, but you can’t integrate all of the **teams** for all of the people”*

## 7.6 Vision

Shared understanding and belief in vision were asked specifically about in the Team Climate Inventory (TCI) and deduced from the responses to the questionnaires and interviews.

In the TCI, vision is analysed using four subscales (Anderson and West, 1996):

- Clarity team members have about the team's objectives
- The perceived value team members place on the team's work
- The extent to which the team collectively share and agree with the team's objectives
- The team's perception of whether the objectives are able to be achieved

The TCI results suggest that the team in case study 3 have the least shared vision and the team in case study 2 the highest (table 7.5, p.177).

Table 7.5 TCI Vision characteristics

|                     | <b>Characteristics</b>  |
|---------------------|---|
| <b>Case study 1</b> | <ul style="list-style-type: none"> <li>• Overall vision score of 40</li> <li>• Clear about objectives of team</li> <li>• Perceive only some value and worth in team's objectives for themselves/organisation/wider society</li> <li>• Some but not all team objectives are shared and agreed upon by team members</li> <li>• Some team members feel objectives are attainable in practice but feel that some objectives may be more attainable than others</li> </ul> |
| <b>Case study 2</b> | <ul style="list-style-type: none"> <li>• Overall vision score of 45.6</li> <li>• Clear about objectives of team</li> <li>• Convinced of value and worth of team's objectives for themselves/organisation/wider society</li> <li>• Team objectives are shared and agreed upon by all team members</li> <li>• Some team members feel objectives are attainable in practice but feel that some objectives may be more attainable than others</li> </ul>                  |
| <b>Case study 3</b> | <ul style="list-style-type: none"> <li>• Overall vision score of 39.4</li> <li>• Clear about some areas of the team's objectives but may be unclear about others</li> <li>• Perceive only some value and worth in team's objectives for themselves/organisation/wider society</li> <li>• Team objectives are not shared and agreed upon by all team members</li> <li>• Team members feel objectives are realistic and attainable in practice</li> </ul>               |
| <b>Case study 4</b> | Insufficient data to explore further  |
| <b>Managers</b>     | Not applicable  |

In case studies 1 and 3 there appeared to be a shared vision for integrated working articulated by team members in both questionnaire and interview responses but which was less supported by the TCI in both cases. Conversely in case study 2 the TCI scored highly on the Vision subscale but less so in questionnaire and interview responses, suggesting support for the notion that the TCI responses for case study 2 were overtly positive and not a true reflection of team climate.

Table 7.6 Vision related characteristics from themes

|                     | <b>Characteristics</b>  |
|---------------------|---|
| <b>Case study 1</b> | <ul style="list-style-type: none"> <li>• Wanting change</li> <li>• Recognising team working barriers</li> </ul>                                 |
| <b>Case study 2</b> | <ul style="list-style-type: none"> <li>• Valuing Care Aims</li> <li>• Leadership and vision</li> </ul>  |
| <b>Case study 3</b> | <ul style="list-style-type: none"> <li>• Conflicting priorities</li> <li>• Care Aims as an enabler</li> <li>• Identifying priorities</li> </ul> |
| <b>Case study 4</b> | Insufficient data to explore further  |
| <b>Managers</b>     | Not applicable  |

Clarity of vision, alongside clear aims and objectives is frequently cited in the literature as a factor influencing integrated team working (Cameron et al, 2000; Hudson, 2006a; Larkin and Callaghan, 2005; Shaw et al, 2011; Thistlethwaite, 2011). In the literature reported case studies (Scragg, 2006; Hudson, 2006a; Tucker, 2010; Syson, 2010) appeared to relate to relatively new teams which may influence shared understanding and clarity of vision. However all the teams in the case studies were well established and many of the team members had been with the team for two years or more. This should have facilitated opportunity for teams to establish a shared vision. In this study there appears to be a negative correlation between level of integrated teamworking and team climate vision score: case study 2 is perceived to work in the least integrated way and has the highest vision score; case study 3 is perceived to be the most integrated team with the lowest vision score.

Boon and Kachan (2008) in a comparison of two American integrated teams found that a highly respected champion was critical to developing integrated working. Whilst the champion needed credibility they did not need to be the manager but essentially had clarity of vision and were able to mobilise others. In both case studies 1 and 3 the team leaders appeared to have vision and were able to motivate (more so in case study 3) their teams, championing a different way of working. The role of the leader in establishing and sharing the vision is well documented (Bradley et al, 2010; Scragg, 2006) although West (2012) suggests that development of team vision is a team activity as there will be greater ownership and commitment to the vision if team members feel they have contributed to it and it reflects their values. In case studies 1 and 3 there were shared leadership models and case studies 1 and 3 appeared to have stronger sense of team vision. Consistent with West's view above regarding

involvement and ownership, shared leadership may potentially support a stronger sense of team vision.

## 7.7 Leadership

In the literature review (chapter 2) leadership was shown to be both a barrier and facilitator to integrated working (Royal Pharmaceutical Society of Great Britain and the British Medical Association, 2000; Johnson et al, 2003; Brown and White, 2006; Gibbons et al, 2002; Outhwaite, 2003; Skidmore and Box, 2009; McCallin and Bamford, 2007). Nancarrow et al (2013) and West and Lyubovnikova (2012) also described leadership as significant factor in team effectiveness and functioning.

Chapter 6 which introduced the case studies described how the leadership and management of the three teams varied but in each case appeared to strongly influence how the team functioned in an integrated way. The different leadership models in each case study are summarised below in table 7.7 (p.179).

Table 7.7 Leadership model for each case study team

|   | <b>Case study 1</b> | <b>Case study 2</b>      | <b>Case study 3</b>               | <b>Case study 4</b> |
|---|---------------------|--------------------------|-----------------------------------|---------------------|
| <b>Number of team leaders</b>                                   | 2                   | 1                        | 3                                 | 1                   |
| <b>Profession of team leaders</b>                               | AHP and nurse       | AHP                      | AHP (three different professions) | AHP                 |
| <b>Professions in team not represented at team leader level</b> | None                | Nurses                   | Psychologists                     | Nurses              |
| <b>Length of time in team</b>                                   | More than 2 years   | Information not obtained | More than 2 years                 | More than 2 years   |

In both case studies 1 and 3 there was evidence to support that the teams had leaders who had established a clear direction and vision for the team, and providing support and supervision to the team members. In case study 2 this appeared less so with one interviewee reporting that the team repeatedly informed the team leader that they were finding Care Aims time consuming and not better than their current ways of working and that the team leader did not seem keen to address this. In case study 2 there was also a suggestion of groupthink (Janis, 1982) where the group were more concerned with the cohesiveness of the group than the strength of decision making. Although it could be argued that by the group reaching consensus they were listened too.

The profession of the team leader also appeared significant. Where there is a mix of professionals in the leadership structure there appears to be greatest integration possibly as the different professional voices feel heard and understood. In case study two the leadership was by one person and not representative of all the professions in the team. In an integrated team it is possible that a more collective approach to leadership is appropriate rather than as Leutz (2005) suggests, having one person in charge. West et al (2014) define collective leadership as:

*“everyone taking responsibility for the success of an organisation as a whole, not just their own job or work area” (p. 4).*

This is also supported by D’Innocenzo et al (2014) who identified that shared leadership in teams is a strong predictor of team performance. This is also supported by the literature that identifies the involvement of front-line staff to create a sense of ownership as a supportive factor in integrated working (Cameron et al, 2000, cited in Blundell 2010; Rees et al, 2004; Skidmore and Box, 2009; Workman and Pickard, 2008). There may be a similar relationship between collective leadership and team vision as described in section 7.6.

Longer term it would be interesting to further explore the team in case study 3, who whilst at present appear to work in the most integrated way, have one of the organising themes was ‘influence of hierarchy’ (figure 6.15, p.154) and the TCI results for case study 3 (figure 6.3, p.94) identified some team members as being more influential than others. A hierarchical way of working would appear to be inconsistent with collective and shared leadership approach yet in case study 3 this did not appear to be an area of concern for the team at present. This may be partially explained by the team’s preferred dominant cultures including hierarchy culture which is a more traditional type structure with respect for position and power. However respondents equally stated a preference for a clan culture. Hierarchy and clan cultures are in many respects contradictory with a hierarchy culture having strict rules and procedures whereas a clan culture drives people through shared goals, team approach. This suggests that whilst team climate may be relatively positive at present it could be less so in the future.

The leadership of the teams may have impacted on how the professions viewed each other and the level of fragmentation that appears to be reported. The key factors appearing to be professional background and length of time in the team. For example in case study 1 the team leaders were an AHP and a nurse who had worked together for many years. In case study 2 there was just one team leader – an AHP. In case study 3 there were three team leaders – an OT, a physiotherapist and an SLT who all

worked together for some time and appeared to make all decisions collaboratively which may impact on how the different professions in the team viewed each other. This suggests support for the findings of the Kings Fund (2015) who reported that leadership has been shown to be the most important influence on culture. Culture in turn influencing how professions work together rather than processes and strategies (West et al, 2014).

Leutz (1999) recognised that asking professionals and managers to work in an integrated way was not only financially costly but also required them to work differently by expanding their knowledge and their perception of their role and to take an interest in services that would normally be outside their scope of practice. Leutz (1999) also acknowledged that this could be perceived as threatening to professionals. Leutz (1999) recognised that those who led integration attempts often focussed projects on the areas that interested them rather than the broader needs of the client group that services were targeted at. Leutz (2005) later explained his rationale for this law describing how different people could look at the same problem and come up with different solutions usually aimed at solving their own problems with uncoordinated and fragmented services. This is supported by Goodwin (2011) who reflected in his blog, that in many cases:

*“dominant professional elites, reflecting their own values and interests above others”*

and that it is unusual to find true coalitions that reflect the values of patients and communities.

In this study the leadership structure in a team appears to affect team culture and the interplay between different professionals. Where there is a mix of professionals in the leadership structure there appears to be greatest integration possibly as the different professional voices feel heard and understood. For example in both case studies 1 and 3, the teams demonstrated the greatest level of integrated team working.

Wylie and Gallagher (2009) identified that some allied health professions had better transformational leadership skills than others and were potentially advantaged when it came to embracing the modernisation agenda. Integrated team working could be perceived as being one aspect of the modernisation agenda. The study found that occupational therapists, physiotherapists and speech and language therapists all displayed consistently higher scores in transformational leadership behaviours than other allied health professions (Wylie and Gallagher, 2009). In case studies 1-4 the

team leaders all came from either occupational therapy, physiotherapy or speech and language therapy. The other aspect Wylie and Gallagher (2009) found significant was the previous level of leadership training respondents had received. Leadership training was not explored in this thesis and may be an area for future research to investigate the impact of leadership training on the ability to lead an integrated team.

Leading an integrated team is recognised as being challenging:

*“you don’t do integration if you want an easy life”* (Bevan Commission, 2013, p.7).

Goodwin (2011) notes that managers may recognise the benefits of leading an integrated team or providing integrated care but may also feel it undermines or fragments their role.

This study did not specifically explore the training that team leaders had received to lead and manage integrated teams as further investigation may give more insight regarding differences between the case studies. Maslin-Prothero and Bennion (2010) identify specific training to manage integrated teams as essential.

In case studies 1, 3 and 4 the team leaders all took part in questionnaires and/ or interviews. This could potentially bias the results as in case studies 1 and 3 the team leaders gave more detailed responses than other team members.

In both case studies 1 and 3 examples were also given of where the team leaders had shared decision making whereas in case study 2, whilst it was reported that the team felt involved in decision making, the group made decisions but the team leader could appear ambivalent. Caution should be applied as only one team member informed the narrative for case study 2.

In the literature, team size is identified as a factor affecting team performance. With a larger team it may be more difficult for a leader to provide effective and visible leadership. The team in case study 3 was the largest (approximately 18 members) but had three team leaders whilst the teams in case studies 1 and 3 were of similar size (approximately 8 members). West (2012) suggests 6-8 team members being an appropriate size for the team. This suggests that in this study team size was not influential.

Perhaps one of the differences between the case studies is the language used in relation to leadership and management. In case studies 1 and 3 the team leaders described themselves and their team leader partners as leaders rather than managers whereas in case study 2 the team leader was referred to as a manager. Whilst the lack of a response from the team leader in case study 2 limits and potentially biases this analysis, it is potentially the difference in leadership and management that influences the team behaviour. This would also lend support to the notion that in case studies 1 and 3 the vision of integrated working and care aims was clear whereas in case study 2 there was a suggestion of implementing care aims, working in a particular way as a task to be completed rather than provision of strong leadership to influence and guide the team towards a shared vision.

Leadership appears to have strongly influenced the effectiveness and extent of integrated working in these case studies and supports Leutz concept of putting the right person in charge of the integration (Leutz, 2005).

## **7.8 Management of Change**

The change process was a common theme across three case studies and the managers' interviews (table 7.8, p.184). Case studies 1, 2 and 3 all identified the process of change as a global theme. From the manager's interviews a receptive context for change was identified as a global theme. The majority of themes identified (table 7.8, p.184) relate to the implementation of Care Aims and not integrated team working. These are explored further in section 8.6.

Table 7.8 Change related themes

|                     | Themes   |
|---------------------|--|
| <b>Case study 1</b> | <ul style="list-style-type: none"> <li>• Wanting change</li> <li>• Learner anxiety</li> </ul>  |
| <b>Case study 2</b> | <ul style="list-style-type: none"> <li>• Valuing Care Aims</li> <li>• The importance of training</li> </ul>  |
| <b>Case study 3</b> | <ul style="list-style-type: none"> <li>• Using Care Aims was natural</li> <li>• Conflicting priorities</li> <li>• Training is important</li> <li>• Managed implementation</li> </ul>   |
| <b>Case study 4</b> | Insufficient data to explore further   |
| <b>Managers</b>     | <ul style="list-style-type: none"> <li>• Receptive context for change</li> <li>• Driving forces for change</li> <li>• Sustaining change</li> <li>• Adapting Care Aims</li> <li>• Challenges of Care Aims</li> <li>• Tangible and less tangible outcomes</li> </ul> |

Whereas the teams in case studies 2, 3 and 4 had been set up as integrated teams, the team in case study 1 had not. Case study 1 had historically consisted of two smaller teams, one of which was integrated and the other containing only nurses. Care Aims training appears to have facilitated the team in case study 1 to discuss and explore their own professional culture and that of other team members in a supportive way. Care Aims training also appears to have encouraged discussion in the team about different approaches to care and provided the opportunity for the team to develop and agree more consistent working practices (section 6.5.7). However, it is unclear whether it was Care Aims itself, or the training and discussion that took place, which enabled this team to develop and agree more consistent working practices.

The impact of change and change management in implementing integrated care is recognised by Leutz (1999) with three of his five laws appearing to relate to this:

*“Integration costs before it pays”* (Leutz, 1999, p.89)

*“Your integration is my fragmentation”* (Leutz, 1999, p.91)

*“You can’t integrate a square peg and a round hole”* (Leutz, 1999, p.93)

Leutz recognised that often when services are brought together to create integrated teams, budgets are cut and the introduction of skill mix is usually associated with the introduction of more, lower level roles. Leutz (1999) describes three types of costs:

- Staff and support systems – integration specific engagement, training and development costs
- Service costs – up front funding of new services based on costing rather than hoping services can self-fund
- Start-up costs – Leutz experience suggested that successful projects had been supported by start-up grants.

Contrary to Leutz's counsel the results of this thesis suggest that need to reduce expenditure was one of the main drivers for change and not integrated working. Some of the manager's expressed frustration that Care Aims had not released the financial savings they had thought it would although this was not expressed by all the managers.

### **7.9 Professional Culture**

The teams in the case studies all contained OTs and physiotherapists with nurses present in case studies 1 and 2 and only speech and language therapists and psychologists present in case study 3. The managers included representation from nursing, AHP and healthcare scientists. Table 6.2 (p.90) shows the professions represented in in each case study. The themes for the professional culture category are shown in table 7.9 (p.186).

Table 7.9 Professional culture themes

|                     | <b>Themes</b>   |
|---------------------|---|
| <b>Case study 1</b> | <ul style="list-style-type: none"> <li>• Recognising team working barriers</li> <li>• Enabling therapists</li> <li>• Differing levels of change</li> </ul>  |
| <b>Case study 2</b> | <ul style="list-style-type: none"> <li>• Misunderstanding roles</li> <li>• Professional disrespect</li> <li>• AHP mutual respect</li> <li>• Professional relationships</li> </ul>   |
| <b>Case study 3</b> | <ul style="list-style-type: none"> <li>• Altered self-perception</li> <li>• Exposing professional cultural differences</li> <li>• Challenging professional cultures</li> <li>• AHPs integrated working</li> <li>• Professional connections</li> </ul> |
| <b>Case study 4</b> | Insufficient data to explore further  |
| <b>Managers</b>     | Insufficient data to explore further  |

In case studies 1 and 3 team members voiced that Care Aims training had caused them to explore their own professional culture and facilitated them to recognise differences from other professional cultures. The team in case study 1 did not appear to see this as a barrier to working together and similar to the teams in Tucker's case study (Tucker, 2010) were seeking ways to resolve this. In case study 1 the team also recognised that there were different professional values in the team but wanted to work together as a team. This appears to differ from case study 2 which suggested:

- Professionals don't understand each other's roles
- OT and physiotherapist see each other as equal
- Mutual respect between OT and physiotherapist
- Less respect shown for the nursing role by AHPs

Case study 2 appeared to suggest that their differences were irreconcilable possibly because the AHP did not appear to view the nurse as an equal: the AHP suggesting that they carried greater responsibility for the patient's care and wellbeing.

In case study 3 similar to case study 1, the team saw the benefits of working together and wanted to work together overcoming professional differences to the extent that one team member described viewing their own profession differently. She reported that the way she worked in her team had become the norm so that until in the company of her own profession away from the team she had not realised how differently she now practiced. However caution should be applied to these findings as they relate to

individuals in the teams and may reflect personal beliefs rather than professional culture. As reported in the literature review (section 2.7) professional culture cannot be neatly separated from an individual's personal, social or professional history. The literature search also identified that the 'right people' or personalities could also act as a barrier or facilitator to integrated working (Cameron et al, 2000, cited in Blundell 2010); Brown and White, 2006; Thylefors et al, 2005; McCallin and Bamford, 2007).

One emerging theme across the three full case studies is the ability of AHPs to work in an integrated way with each other but less so with other professions unless their philosophical perspective of care and standing is similar. In case study 1 there appeared to be a shift in the nurses' perception of how care should be delivered in the future moving to be more similar to the AHPs. The sharing of a similar perspective was between two experienced and senior staff (an AHP and a nurse) which is similar to the findings of Baxter and Brumfitt (2008) who proposed that for the blurring of boundaries to occur there needed to be an in-depth understanding of the knowledge of that profession which could only be achieved by expert or experienced practitioners. Similarly Beales (2011) identified that health care professionals needed enough inter-professional collaborative experience to develop an integrated team culture. These knowledge boundaries i.e. the phenomenon that emerges when individuals of different 'thought worlds' are unable to synthesise or unwilling to share their knowledge (Smith, 2016) may be the cause of fragmentation.

It is possible that the perception of fragmentation relates to resisting loss of professional autonomy as with increased integration comes reduced professional autonomy (Boon et al, 2004). This may be more difficult for some professions to accept dependent on the value placed on professional autonomy by the profession. Rafferty et al (2001) found a positive association between teamwork and autonomy for nurses although the study primarily explored nurses working in teams consisting mainly of doctors and nurses. Historically nursing as a profession has been less autonomous than many of the allied health professions such as physiotherapy, occupational therapy and speech and language therapy. It is of note that the Nursing and Midwifery Council (NMC) Standards of conduct, performance and ethics for nurses and midwives (2008) does not specifically mention autonomy whereas the Health and Care Professions Council (HCPC) Standards of conduct, performance and ethics (2016) does.

Leutz's third and fourth laws (Leutz, 1999) (table 2.3, p.19) could both be seen to reflect professional and team cultures. Some professionals may feel increasingly isolated as their team develops more integrated ways of working which may feel

contradictory to their professional culture; a reflection of feeling like a square peg in a round hole. Tucker (2010) explains this law as meaning that some differences cannot be resolved. It is unclear whether this is an active choice or default position, reverting to traditional professional culture.

## **7.10 Team Culture and Climate**

Individual perception of fragmentation may also be a reflection of team climate.

As reported in chapter 6 responses to the TCI were received from each of the teams in case studies 1, 2, 3 and 4. Whilst the response rates varied and in each case study were below the recommended response rate of 75% (Anderson and West, 1996) the results do give some insights into team climate (table 7.11, 190). The TCI for case study 4 could not be scored as there was only one response so the narrative relating to this is based on the raw data in the TCI questionnaire.

Case studies 1, 2 and 3 all reported positive team climates on the TCI (table 7.11, p.190). Both case studies 1 and 2 showed high social desirability scores (table 7.10, p.189) with the social desirability score for case study 2 being much greater than case study 1. Whilst case study 2 scored highly (and overly positive) for social and task aspects, case study 1 only scored highly (and overly positive) for the social aspect. This could suggest that team members wished to portray team climate much more positively than it really was, with the implication that team was not functioning as well as a team as it wanted to be perceived. Contrary to this team turnover was suggested to be "*quite static*" in case study 2 (AHP 1, p.9, line 34). It could be expected that if team climate was poor then turnover would be high.

Table 7.10 TCI Social desirability results

| <b>Case study</b> | <b>Social aspect narrative result</b>  | <b>Social aspect raw score</b> | <b>Task aspect narrative result</b>  | <b>Task aspect raw score</b> | <b>Total social desirability score</b> |
|-------------------|--|--------------------------------|--|------------------------------|--|
| 1                 | <p>Team members claim never to feel tense with each other and maintain there is constant harmony in interpersonal relations within the team.</p> <p>There are likely inaccuracies over reported social climate to portray the team too favourably</p>                    | 13.0                           | <p>Team members claim the team functions well and achieves most targets. Team members believe the team to be one of the better in its field.</p> <p>There may be some inaccuracies over reported social climate to portray the team rather favourably</p>        | 9.5                          | 22.5                                   |
| 2                 | <p>Team members claim never to feel tense with each other and maintain there is constant harmony in interpersonal relations within the team.</p> <p>There are likely inaccuracies over reported social climate to portray the team too favourably with relative ease</p> | 13.2                           | <p>Team members claim the team always functions well and achieves all targets with ease. Team members believe the team to be the best in its field.</p> <p>There may be some inaccuracies over reported social climate to portray the team rather favourably</p> | 12.0                         | 25.2                                   |
| 3                 | <p>Team members claim rarely to feel tense with each other and maintain there is harmony in interpersonal relations within the team.</p> <p>There may be some inaccuracies over reported social climate to portray the team too favourably</p>                           | 9.4                            | <p>Team members claim the team always functions well and achieves all targets with ease. Team members believe the team to be the best in its field.</p> <p>There may are likely inaccuracies over reported social climate to portray the team too favourably</p> | 11.0                         | 20.4                                   |
| 4                 | Insufficient data to explore further   |                                |  |                              |  |

Team climate has been shown to correlate positively with team type. Thylefors et al (2005) found that the greater interdependence and co-operation the better team climate was. This may relate to integrated teams having a more shared vision, better and more frequent communication processes and potentially spending more time together than a collaborative or coordinated team. In this study the perceived level of team integration appeared to relate negatively more so with the social desirability score as well as the overall team climate. Case study 3 is perceived to be the most integrated team and had the lowest social desirability score whilst case study 2, perceived to be the least integrated team had the highest. Similar to the social desirability scores, the overall team climate (excluding the social desirability scores), appeared to be less positive in the teams perceived to be the most integrated (table 7.11, p.190). For example case study 3 had one area as requiring structured intervention, case study 1 had 3 areas identified as benefiting from improvement and case study 2 had only 1 area which would benefit from some improvement. This appears contrary to the findings of Thylefors et al (2005) and also suggests that the social desirability scores may be as significant as overall team climate.

Table 7.11 Summary of TCI results for case studies 1, 2, and 3

| Scale                         | Subscale              | Case study 1 | Case study 2 | Case study 3 |
|-------------------------------|-----------------------|--------------|--------------|--------------|
| <b>Participative safety</b>   | Information sharing   | Green        | Green        | Green        |
|                               | Safety                | Green        | Green        | Green        |
|                               | Influence             | Green        | Green        | Green        |
|                               | Interaction frequency | Green        | Green        | Green        |
| <b>Support for innovation</b> | Articulated support   | Green        | Green        | Green        |
|                               | Enacted support       | Green        | Green        | Green        |
| <b>Vision</b>                 | Clarity               | Green        | Green        | Green        |
|                               | Perceived value       | Green        | Green        | Green        |
|                               | Sharedness            | Yellow       | Green        | Red          |
|                               | Attainability         | Yellow       | Yellow       | Green        |
| <b>Task orientation</b>       | Excellence            | Green        | Green        | Green        |
|                               | Appraisal             | Yellow       | Green        | Green        |
|                               | Ideation              | Green        | Green        | Green        |

-  Climate appears sound
-  Identified as an area which would benefit from improvement
-  Identified as requiring structured and intensive intervention

It is of note that Anderson and West (1996) suggest that a high social desirability response can lead to groupthink as is suggested to have occurred in case study 2. Looking specifically the aspects of the TCI related to trust, valuing of contributions and consensus (table 7.12, p.191) the scores for case studies 1 and 2 are significantly higher than for case study 3 suggestive of bias. The particularly low influence score for case study 3 is consistent with the theme of hierarchical behaviour as described in section 6.7.8.

Table 7.12 TCI scores for information sharing, safety, influence and ideation

|                            | <b>Case study 1</b> | <b>Case study 2</b> | <b>Case study 3</b> |
|----------------------------|---------------------|---------------------|---------------------|
| <b>Information sharing</b> | 10                  | 10                  | 9                   |
| <b>Safety</b>              | 10                  | 10                  | 6                   |
| <b>Influence</b>           | 9                   | 8                   | 4                   |
| <b>Ideation</b>            | 10                  | 10                  | 7                   |

Both case studies 1 and 2 reported high social desirability scores on the TCI i.e. the need to be overly positive about team climate. In case study 1 the respondents with the exception of 1 had all been with the team for longer than 2 years. In case study 2 whilst the response rate was very low the questionnaire and interview results suggested that the majority of team members had been with the team for more than 2 years. In case study 3 approximately 75% of respondents had been with the team for more than 2 years with the remaining 25% being with the team for 1-2 years. In each case it is suggested that the teams had sufficient collective experience for the team to build relationships.

In the TCI results only case study 2 identified that team members shared and agreed the team objectives. In both case studies 1 and 3 there was less agreement. However in the thematic network in both case studies 1 and 3 there appeared to be more agreement expressed about how the team was and wanted to work and less in case study 2.

Given the concerns over social desirability bias identified for case study 2 it is possible that both case studies 1 and 3 are more aligned in terms of individual characteristics. Syson and Bond (2010) identified that co-location could facilitate team building and the behaviours and skills identified by Nancarrow et al (2013) e.g. knowledge, knowing strengths and weaknesses, listening skills, reflexive practice; desire to work on the

same goals. Whereas the team in case study 3 were co-located the team in case study 1 were not but aspired to be. Interestingly the team in case study 2 were co-located with the team in case study 3 but seemed to display different behaviours and culture.

Case studies 1, 2 and 3 all expressed a desire to innovate although case study 1 as identified earlier felt they needed help with this. West (2012) notes that clarity of team vision (section 14.4.8), team participation, task focus and support for innovation all influence the ability of a team to innovate. In case study 2 there was less clarity of vision than in teams 1 and 3. All three teams scored highly on the TCI for innovation.

In case studies 1, 2 and 3 examples were given of communication processes such as team meetings and of shared discussion including in relation to patient care. The TCI report for all three teams stated that they made:

*“genuine attempts to share work related information. Individuals pass on information to others extensively and regularly”* (TCI report, case study 1, p.3).

Although again for case study 2 this was with the caution that the results showed high likelihood of being overly positive to portray the team in a more positive light than in reality.

All three teams also reported that their teams met frequently and interacted both formally and informally. In all three case studies examples were given of team members debating and discussing Care Aims and team processes.

The teams in case studies 1, 2 and 3 all appeared to report good levels of communication with the difference appearing to be how decisions were made. Further exploration of these elements may highlight differences between the case studies. For example in their study exploring the effectiveness of multi-professional team working in mental health care, West et al (2012) make specific recommendations about the chairing and organisation of team meetings. West et al (2012) recommended that meetings had clear agendas, ensuring that the purpose of the service for service users was the central theme of most meetings, meetings chaired by someone who has been trained to chair meetings, encouraging everyone to share their views but seeking the views of those with expertise early on in the discussion and moving quickly to a decision once views and opinions have been expressed and discussed and acknowledging and thanking people for their contribution.

Although there were AHPs in all three teams how the different professions interacted varied across the three teams. This could be due to the influence of team climate and culture. Or as described earlier this may be due to a perception of professional hierarchy and/or loss of autonomy and/or impact of leadership on the team.

The right personalities may perhaps be explained by team members displaying emotional intelligence. Emotional intelligence has four elements – self-awareness, self-management, social awareness and managing relationships (West, 2012). McCallin and Bamford (2007) note that this element of team effectiveness has been given less attention. McCallin and Bamford (2007) found that emotional intelligence supported the development of interprofessional safety as team members were better able to consider alternative viewpoints and recognise the value different team members and professions offered. This is similar in many respects to the notion of creating psychological safety that Schein (2010) describes as necessary for supporting managed change.

The wording of several of the competency statements by Nancarrow et al (2013) for good interdisciplinary team working also suggests a preference for a dominant clan cultural type. Ironically only the OCAI results for the current cultural dominant type in case study 2 was clan although all case studies 1 and 2 stated a preference for a dominant clan culture in the future. For case study 3 this was shared with the adhocracy cultural type. None of the teams in case studies 1, 2 or 3 showed agreement within their teams as to the current dominant cultural type either.

Case study 1 identified different current cultures but wanted similar future cultures. Case study 2 showed less overall change between current and future culture but demonstrated a slight shift towards a more clan culture. Case study 3 showed no one dominant culture now or in future but the future cultures were different from the current cultures. These results suggest the OCAI was less conclusive in helping understand team culture. However caution should be applied as the numbers of respondents on which these results are based are small.

Table 7.13 OCAI results: Perception of dominant cultural type

|                     | Perception of dominant cultural type    |  |
|---------------------|---|--|
|                     | Current                                 | Preferred                                    |
| <b>Case study 1</b> | Clan (1)<br>Market (1)                  | Clan (2)                                     |
| <b>Case study 2</b> | Clan (3)<br>Hierarchy (2)               | Clan (4)<br>Adhocracy (1)                    |
| <b>Case study 3</b> | Clan (1)<br>Market (2)<br>Hierarchy (1) | Clan (2)*<br>Adhocracy (2)*<br>Hierarchy (1) |
| <b>Case study 4</b> | Market (1)                              | Adhocracy (1)                                |
| <b>Managers</b>     | Market (2)                              | Clan (1)<br>Market (1)                       |

() denotes number of responses with this as dominant cultural type

\*one respondent had 2 equally scored dominant types

The TCI and OCAI results for case study 2 appear at odds with the narrative in the interviews in relation to respect and understanding roles (section 7.11) the team are reported as being “*pretty closely knit*” with low turnover of members (case study 2, interviewee 1, p.9, line 36).

Lemieux-Charles and McGuire (2006) identified that a context of ‘*enhanced team orientation*’ (p.286) was found to promote perceived team effectiveness although they do not identify whose perception this was. A dominant clan culture as identified by the OCAI could be an indication of ‘*enhanced team orientation*’ as could positive team climate using the TCI. However positive team effectiveness is not necessarily an indicator of positive team integrated working.

On reviewing the TCI subscale results i.e. the potential for high social desirability bias, the different perceptions in the teams as to the team’s current dominant cultural type and the low response rate it is difficult to conclude which of the teams in case studies 1, 2 or 3 has the most positive team climate.

### 7.11 Staff Roles, Responsibilities and Relationships

In the literature review it was reported that clarity about roles and responsibilities is well recognised as an influencing factor in integrated team working (table 2.4, p.31).

In both case studies 1 and 2 clinicians appeared to stay within clearly defined professional boundaries with some specific additional but very clearly defined duties in case study 2. In case study 2 there were clearly defined roles aligned to individual professions but there appeared to be different levels of respect suggested between the professions particularly between AHPs and nurses. In case study 1 unlike case study 2 there appeared to be collaboration and respect between AHPs and the nurses. In case study 3 there was greater role blurring although supervision and other support mechanisms were articulated between the AHPs to facilitate this. However in case study 3 there was little mention of the psychologist within the team. If the psychologist had responded it would have been interesting to explore whether their responses indicated a feeling of isolation from the rest of the team. Themes relating to roles and responsibilities emerged in each case study (table 7.14, p.195).

Table 7.14 Role and responsibility themes

|                     | Themes  |
|---------------------|---|
| <b>Case study 1</b> | <ul style="list-style-type: none"> <li>• Clarifying team role and responsibilities</li> </ul>                           |
| <b>Case study 2</b> | <ul style="list-style-type: none"> <li>• Misunderstanding roles</li> <li>• Role extension</li> </ul>                    |
| <b>Case study 3</b> | <ul style="list-style-type: none"> <li>• Understanding scope of practice</li> <li>• Professional connections</li> </ul> |
| <b>Case study 4</b> | No themes identified – insufficient information   |

Responses from the teams in case studies 1, 2 and 3 identified that all teams were skill mixed and included a range of professions (table 6.2, p.90) and also a mix of staff from grade bands 3-7 (band 5 being the payband that newly qualified professionals enter).

In both case studies 1 and 3 the role of band 3 and 4 staff was positively talked about and examples were given of how staff in these roles particularly delivered integrated care:

*“She’s working across the whole of the team”* (case study 1, AHP 1, p.10, line 12)

*“They’re the lynch pin that pull it all together and are generic”* (case study 3, AHP 2, p.9, line 11).

Whereas in case study 2 the rehabilitation assistants appeared to deliver uni-professional care:

*“the patient was passed on to the rehabilitation assistant to complete the exercise programme which was structured over 6 weeks but they also had*

*some OT activity practices to do with that exercise plan (case study 2, AHP 1, p.5, line 9).*

In both case studies 2 and 3 team members described how they had been trained to deliver aspects of care traditionally provided by other professions although the extent of this varied. For example in case study 2 interviewee 1 described specific tasks whereas in case study 3 there appeared to be a broader approach to training which also related to the process of care e.g. the initial assessment could be carried out by any qualified member of the team.

Whilst this study did not explore whether the skill mix was considered appropriate for the activities the team undertook, in case studies 2, 3 and 4 reference was made to demands being placed on the team and a potential mismatch between capacity and demand.

The experience of the team is drawn from the team questionnaire results. The response rate varied greatly between the teams so only an indication of team experience can be drawn.

In case study 1 team members appeared to demonstrate understanding and acknowledgement of their different professional cultures (figure 6.10, p.115). It was expressed that the Care Aims training facilitated this conversation and enabled the team to find common ground and a shared vision to go forward (figure 6.11, p.126). However there was a suggestion that AHPs worked in a more enabling way with patients compared to nurses and that this was better (figure 6.10, p.115).

In case study 2 (section 6.6.7) there appeared to be a lack of respect for nurses in the team expressed by an AHP although caution should be applied as this was the response of one individual. AHP 1 said:

*“The nurse was just generally monitoring people so she wasn’t actually taking, doing active treatment” (case study 2, AHP 1, p.8, line 14).*

It was also suggested that the OT and physiotherapists undertook assessments together and if nursing input was felt to be required an internal referral was made.

In case study 3 (section 6.7.8) there appeared to be a shared understanding of roles and team members had and appeared to continue to have training about elements of each other’s role. As described earlier (section 6.7.9) the use of functional goals also

appeared to facilitate a shared understanding and contribution to the plan of care for the patient.

Whilst the teams in both case studies 2 and 3 had undergone additional training to extend their roles, this did not appear to have happened in case study 1. The lack of extended role training whilst not explicitly explored as part of this study did not appear to impact on understanding the roles and professional cultures within the team.

Within each of the case studies respondents were able to describe their own role although in all the case studies (1, 2 and 3) the team were inconsistent in their definition of team type.

This study only explored Care Aims training and no other types of training that may support integrated team working such as training to support role expansion or leading an integrated team. Belling et al (2011) propose that training should be prioritised in integrated team working supporting the findings of West and Lyubovnikova (2012) that team training interventions could facilitate more effective interdisciplinary teamwork. Similarly training may help team members understand each other's roles and responsibilities (Maslin-Prothero and Bennion, 2010). Conversely Syson and Bond (2010) described the impact poor training had on integrated team working in their case study.

In the literature it is well documented that role understanding, respect and professional cultures impact on joint working (Cameron et al, 2000; Blundell, 2010; Royal Pharmaceutical Society of Great Britain and the British Medical Association, 2000; Brown and White, 2006; Gerrish, 1999). Closely related whilst not explicitly explored may also be the level of emotional intelligence individuals within a team possess: being aware of, able to control and express their own emotions well could influence the levels of respect and power sharing individuals in a team are able to demonstrate.

### **7.12 Role and Relationship with Patients**

One of the essential aspects of providing integrated care (Shaw et al, 2011) and therefore integrated team working is the involvement and engagement of patients and keeping patients central to the delivery of care. However in the literature review it was also reported that the views of patient's regarding integration is an area with significantly less research and that most of the literature reports the perspective of

staff. Similarly in this study the relationship with patients appeared to be well articulated by staff. There was less data to explore how patients viewed their role in care and their relationship with staff. The themes that emerged in the case studies are shown in table 7.15 (p.198).

Table 7.15 Themes relating to role of and relationship with patients

| Source              | Themes  |
|---------------------|---|
| <b>Case Study 1</b> | <ul style="list-style-type: none"> <li>• Historical paternalism</li> <li>• Enabling therapists</li> <li>• Empowering patients</li> <li>• Involving other professionals</li> </ul>   |
| <b>Case Study 2</b> | <ul style="list-style-type: none"> <li>• Patients understanding their role Patients feel they are partners in care</li> <li>• Patients value goal setting</li> <li>• Being the expert</li> <li>• Being paternal</li> <li>• Perception of partnership working</li> <li>• Perception of integration</li> <li>• Positive patients</li> <li>• Overly positive patient response</li> </ul> |
| <b>Case Study 3</b> | <ul style="list-style-type: none"> <li>• Patients' perception of integration</li> <li>• Active patient role</li> <li>• Positive patient experience</li> <li>• Goal attainment</li> <li>• Patient centredness</li> <li>• Differing goals</li> <li>• Personal patient goals</li> </ul>  |
| <b>Case Study 4</b> | No themes identified – insufficient information   |
| <b>Managers</b>     | No themes identified  |

In each case study the relationship with patients varied. In case study 1 there was recognition that the reported medical model of working was not in patients' best interests and the team aspired to a more partnership approach. Interviewee 1 described several aspects to this which included letting patients take responsibility for their decisions, supporting patients to self-manage their conditions and make choices and working collaboratively/in partnership with patients.

In case study 2 a more medical model of care was described. AHP 1 described having barriers with patients and wanting to keep things simple for patients. The patient responses for case study 2 were all very positive with patients having clarity about what is expected of them and knowing what their role is. There would appear to be an

inconsistency between how patients view themselves and their relationship with staff and how the staff viewed the patients. The positive responses from patients could also question whether integrated team working is essential for positive patient outcomes.

In case studies 1 and 2 patients are not fully regarded as partners in care unlike case study 3. However in case study 1 the team recognise that they do not see patients as partners and want to work differently. In case study 2 the team perceive they treat patients as partners but then describe their relationship differently, suggestive of a medical model or one where the balance of power is with the clinician. This may influence how they relate to patients and provide care.

Compared to case studies 1 and 3, case study 2 could be perceived as working in the least integrated way but appear to have the most positive response from patients not only by the greatest response rate (although still low in number) but also by the content of their responses. There are several possible conclusions:

1. patient responses were overly positive (high social desirability response) (section 6.6.4)
2. the team do work in a more integrated way than described and the results are significantly biased
3. patient care does not need to be integrated to provide good outcomes and experience for patients.

This potentially supports the findings of Kane et al (2011) whose literature review found that team care seemed more likely to improve the processes of care rather than outcomes. Due to the sample size and lack of patient responses for case studies 1 and 3 it is not possible to draw any further conclusions.

In case study 3 there appeared to be a more partnership approach with patients. The use of functional goals appeared to facilitate this and this is supported by the patient interview also.

### **7.13 Philosophy and Approach to Care**

At the centre of the categories (figure 7.1, p.171) is the philosophy/approach to care which is influenced by and in turn will also influence the categories described earlier in this chapter. Table 7.16 (p.200) summarises my perception of the model of care in each case study.

Table 7.16 Perception of dominant philosophy and approach to care in each case study.

| Source       | Perceived philosophy and approach to care   |
|--------------|---|
| Case study 1 | <ul style="list-style-type: none"> <li>• Biomedical model appears to dominate for nursing responses and less so for the AHPs.</li> <li>• AHPs appear to have a more whole person approach with the patient actively participating in care, focus on impact</li> </ul> |
| Case study 2 | <ul style="list-style-type: none"> <li>• Biomedical model of care appears to dominate</li> </ul>  |
| Case study 3 | <ul style="list-style-type: none"> <li>• Whole person approach</li> <li>• Integrative, functional and impact focussed</li> </ul>  |
| Case study 4 | No themes identified – insufficient information   |
| Managers     | No themes identified  |

As described in the previous section, the relationship with patients varies greatly between the case studies. Where a more biomedical approach exists, the relationship with the patient is more directive whereas when this model is less used, patients are more actively involved in decisions about their care and also expected to take a more active role in achieving the goals identified. If we return to the spectrum of team working suggested by Boon et al (2004) as teams and therefore potentially care becomes more integrated, the professional has to sacrifice increasing degrees of autonomy. Traditionally this this has been interpreted to mean towards other professionals but I propose that this could also include patients. As discussed in the literature review only by giving up professional autonomy to patients can truly integrated care be provided. This may be more difficult for some professions than others either due to culture or perception of code of conduct which in turn will inform culture. This leads to laws 3 and 4 “*integration is my fragmentation*” (Leutz, 1999, p.91) and “*square pegs and round holes*” (Leutz, 1999, p.93).

All three teams were using Care Aims to varying degrees which does have the potential to facilitate a more patient focussed and partnership approach (Waterworth et al, 2015) although as the staff in case study 3 noted, Care Aims was similar to how they were previously working but it did help finesse the use of functional goals. Functional goals are by their nature patient rather than profession centred and can be defined as:

*“individually meaningful activities that a person cannot perform as a result of an injury, illness or congenital or acquired condition, but wants to be able to accomplish”* (Randall and McEwan, 2000).

Whilst Randall and McEwan (2000) gave this definition in the context of physiotherapy practice, the ability to focus in this way keeps patients at the centre of care whilst providing potential opportunities for care to be provided outside of traditional boundaries or practice and therefore to be more integrated. Being able to set functional goals is potentially more applicable to patients who would be identified as needing coordinated or fully integrated services (tables 2.3, p.19 and 7.2, p.173). In case study 3, narratives from the team responses suggested that the team worked in a very integrated way to the extent that patients have one care plan, use functional rather than profession specific goals with most members of the team described as having extended roles. In case study 1 there appears to be a desire to work more in this way but team members appear to be finding this more difficult to implement. In case study 2 there is less indication that care is being delivered in an integrated manner but is being delivered in a coordinated way. Yet if the team's respective caseloads are mapped to the framework shown in tables 2.3 (p.19) and 7.2 (p.173) then all would appear to have patients with similar types of need. All three case studies had the potential to do this but only one, case study 3, appeared to be able to fully implement this suggesting that team working is more influential than patient illness, condition or disability.

Leutz (1999) used the example of the differences between acute and long term care as the reason why attempts to integrate had been thwarted. He went onto explain that this was due to the differences in systems and the context in which they operated and their cultural and philosophical differences. When Leutz reviewed his laws in 2005 (Leutz, 2005) he expanded on this point detailing the potential types of differences between health and social care. Whilst the terminology suggested Leutz was comparing health and social care, the definition of clinical orientation was from a medical perspective and did not appear to acknowledge that within health there are a range of 'clinical orientations' as some professions do not diagnose and cure disease.

Goodwin (2011) interprets this as the need to adapt a model of integrated care that suits the local situation rather than imposing a model just because it has been successful elsewhere. This suggests support for the importance of context and appears consistent with the notion of receptive contexts for change (Robert and Fulop, 2012; Pettigrew et al, 1992).

Case studies 1, 2 and 3 described processes in place such as team meetings. In all four case studies there was also evidence of procedures such as referral criteria, referral forms and triage to facilitate the work of the team.

All the teams appeared to follow a process of referral, triage, assessment and goal setting. Where this differed between the case studies was that in case study 3, functional goal setting was used where patients identified one key goal and the different professionals identified how this would be met but this was structured in one plan. Whereas in case studies 1 and 2 there was evidence to suggest uni-professional assessment and goal setting. In case study 1 it was also acknowledged that the care a patient received depended on which profession the clinician was from. Functional goal setting is well aligned to the Care Aims paradigm and may also be a reflection on the acceptance and embedding of Care Aims in case study 3.

In section 7.11 it was discussed how the role of band 3 and 4 staff and their involvement in team discussion and apparent perception by their team varied. In case study 2 how band 3 and 4 staff were described would appear in line with the biomedical model and a hierarchical underpinning of clinicians thinking.

#### **7.14 Summary**

The cross case synthesis for integrated team working identified ten categories. Some of the categories identified were similar to themes identified in the literature exploring facilitators and barriers to integrated team working, such as leadership, staff roles and responsibilities, vision and professional culture. However different categories also emerged e.g. service type, team climate and relationship with the patient. The interdependency between the categories is also apparent, with philosophy and approach to care influencing all.

Exploration of the category 'service type' indicated that all the case study teams appeared to have potential to be fully integrated. Team type explored the range of perceptions team members held about the type of team they worked in and this was potentially more influential on integrated team working than service type. However role descriptors given by team members did not appear to support their perception of team type.

Similar to previous studies understanding and belief in the team's vision were also shown to be important. As in previous literature, leadership was important. The cross case analysis showed the combined impact of the profession of the team leader and having a shared or collective approach to leadership. This appeared to influence level of engagement of different team members and extent of integrated working.

Three of the case studies had change management or process as a global theme and had managed change differently. The findings of this section appeared to support previous literature about managing change and receptive contexts for change.

Similar to the literature, professional culture appeared to impact on integrated team working. However the cross case analysis suggested specifically that AHPs were able to work in an integrated way with each other but less so with other professions if other professions were not perceived to share their philosophical approach to care or have similar standing. This may influence team climate and culture or be influenced by team climate and culture.

Corroborating the findings of earlier studies, the most integrated teams were where team members understood their scope of practice but also had greater blurring of role boundaries. The relationship with patients was also different in the more integrated teams working more closely in partnership with patients, facilitated by the use of functional goals. This would appear to provide empirical evidence to support theories for integrated team working previously identified (section 2.5) that as a team becomes more integrated the extent to which medical model of working can be used reduces.

A lack of contextual detail in published case studies prevented cross case analysis of published case studies with the case studies in this study. However this chapter was able to report the findings of a cross case analysis of four case studies, exploring four case studies from the same organisation. Together the ten categories identified during the cross case analysis demonstrate the significance of context on integrated team working.

## CHAPTER 8

### IMPLEMENTING CARE AIMS: A CROSS CASE ANALYSIS

#### 8.1 Introduction

During the cross case analysis it became apparent that Care Aims implementation and use varied between the case studies. This chapter reports the findings of the cross case analysis exploring Care Aims implementation and use. As described in section 7.2, Yin's (2012) approach to cross case synthesis by comparing and contrasting the case studies and developing word tables and categories was used. Whereas chapter 7 explored the categories and word tables in the context of integrated team working this chapter they are explored in the context of implementing Care Aims.

#### 8.2 Service Type

Malcomess (2015) identifies that Care Aims can be adapted to "*any practice, context, team structure or professional group*" suggesting that type of service should not influence use of Care Aims.

Whilst all the case study teams were integrated and contained, the services appeared to share similar features to those in the literature where Care Aims appeared to have been successfully implemented. For example Stansfield (2011) and Millar et al (2013) both describe services which are community based, provide targeted/specialist assessment and intervention with access to services by referral. This is similar to the service characteristics of all four case studies shown in table 7.1 (p.172).

Malcomess (2015) suggests that rather than the preferred approach being direct intervention, in Care Aims the preferred approach is to support self-help and universal services through consultancy (table 3.1, p.46). Respondents from all of the case studies used the words 'intervention' or 'treatment' to describe the service their team provided suggesting that it is this aspect that limits Care Aims implementation more than other aspects described earlier in this section. In both case studies 1 and 3 where Care Aims appeared to be more successfully implemented, there appeared to be a greater expectation of patients to actively participate in their care: active participation in care being akin to self-help. Whereas in case study 2 this was less so:

*“equally the person has to participate”* (case study 1, AHP 1, p.6, line 27)

*“we did the goal setting sheet.....so they know what they’re expecting off us”* (case study 2, AHP 1, p.5, line 7)

Being able to work using a consultancy type model than by direct intervention also requires the support of commissioners. In case study 3 where Care Aims appeared to be successfully implemented, one of the basic themes that was identified was the conflict between Care Aims and commissioning priorities:

*“we’re not commissioned to do anything that’s pre-referral so that instantly dictates what you do and its almost a shame really that we’re not”* (case study 3, AHP 2, p.3, line 15).

Whereas in case study 3 this appeared to be acknowledged as a frustration the team still implemented Care Aims and recognised the limitations of what they could do. In case study 2 commissioning arrangements appeared to limit Care Aims implementation:

*“the selection criteria for the service was quite strict anyway due to commissioning arrangements so it (triage documentation) didn’t really have much bearing ....so we decided to get rid of that bit”* (case study 2, AHP 1, p.3, line 29).

Whilst all the case studies appeared to be the type of service where Care Aims could be implemented successfully this was not the case in practice. The ability or potential of a service to change from providing direct intervention to a more self-help and universal services through consultancy model appears to be an important but not completely limiting factor for Care Aims implementation. Whilst not explicitly explored in this thesis this could be an area for future research. Moving to this way of working may also be reliant on commissioner engagement and support. Commissioner involvement was not specifically explored with respondents and none of the case studies identified whether they had included or invited commissioners to be involved in Care Aims training or implementation.

### **8.3 Team Type**

Malcomess (2015) suggests that Care Aims can be adapted to any team structure. Whilst the literature review suggested that early Care Aims studies had involved uni-professional teams, later studies have included teams with more than one profession. However the literature review (section 3.5) found only three studies where Care Aims had been used in an integrated team. One of those (Waterworth et al, 2015) reported

the findings of the pilot study in this thesis and the other reported the findings of a survey exploring goal setting in stroke rehabilitation (Scobbie et al, 2015). The third explored the use of Care Aims in a multidisciplinary adult learning disability service (Stansfield and Matthews, 2014).

Section 7.5 concluded that the case study teams from the most to least integrated were case study 3, case study 1 and case study 2. There was insufficient data to draw any conclusion about case study 4. Case study 1 was defined as collaborative (table 7.4, p.174) i.e. practitioners practice independently from each other and collaborations are ad hoc and informed on a case by case basis and case study 2 coordinated and case study 3 integrative.

The level of team integration appeared to correlate with the success of Care Aims implementation. Whether this supports the claim in chapter 2 that Care Aims had the potential to promote integrated team working or whether integrated team working facilitates Care Aims implementation is unclear. In case study 1 respondents suggested that Care Aims had facilitated them to explore and understand their own and others' professional culture and provided the team with a shared framework for clinical decision making and delivery of care. In case study 3 the team described how Care Aims had required very little change of them and had reinforced that they were working in a positive way. The parallels between integrated working and Care Aims particularly in relation to person centred thinking and movement away from a medical model of working. For example Care Aims is described as an entirely person centred approach using impact/foreseeable impact for the person and the frame for risk assessment (table 3.1, p.46) (Malcomess, 2015). Person-centred care from the perspective of the individual is described as the:

*“guiding principle for all multidisciplinary/integrated teams, regardless of organisational setting”* (NHS England, 2015, p.27).

Integrated teams are considered to have far less reliance on a medical model of care (Boon et al, 2004) similar to Care Aims (Malcomess, 2015).

It is also possible that in the less integrated teams there was greater potential for Care Aims to be interpreted and adapted differently. Using the definitions of Boon et al (2004) in a collaborative team practitioners practice independently; in a multi-disciplinary team each member of the team makes their own decisions and recommendations for care which may be integrated by the team leader; in an integrated team decision making is guided by consensus and is shared, care is patient

centred. Similarly as teams become more integrated they adopt a less biomedical and more whole person/patient centred model of care which is closer to the Care Aims paradigm. Whilst it is possible in a collaborative team for team members to have a more holistic patient centred model of care, there is greater potential for there to be a range of approaches to care making Care Aims implementation more difficult.

Whilst the reason for the apparent relationship between level of team integration and success of Care Aims implementation is unclear, it would appear that team type is significant.

#### **8.4 Vision**

Care Aims is described as a philosophy (Malcomess, 2015). This could imply that Care Aims implementation is the means to the end and not the end itself. Malcomess (2015) appears to acknowledge this by suggesting that prior to implementing Care Aims services need to identify the outcome they are looking for so there can be discussion whether Care Aims can achieve this. This has parallels to Fuda's (2009) comments about change management in which he observes that one of the common assumptions mistakenly made about change management is that often the focus is on the change and not on the goal that the change is aimed at achieving.

In the case studies where Care Aims appears to have been viewed as a means to helping the team achieve particular goals towards their vision it appears to have been more successfully implemented. For example in case study 1, the team wanted to work more in partnership with and empower patients, wanted to work as a more integrated team and wanted other teams to recognise their specialist role (table 6.6, p.105). Care Aims was viewed as an enabler to do this. In case study 2 Care Aims appears to have been seen as something the team need to implement and not part of the team's vision for the future (table 6.8, p.125). In case study 3 the team appeared satisfied working as an integrated team and wanted to work together with patients (table 6.10, p.146). Use of functional goals within the Care Aims framework helped them achieve this. Similar to case study 1, Care Aims was not the goal or vision but a means to achieving their goal and a step closer to their vision for the service.

The management team described having to '*trust the people who were selling the vision*' (Manager 3, page 2, line 20). Whilst all three managers identified wanting clinicians to be able to articulate their decisions this did not appear to be the vision they

collectively aspired to. All three managers were able to describe drivers for change but these were different and included reducing waiting times, better value for money and wanting clinicians to lead change. Where services identify reducing waiting times as the outcome they are looking for Care Aims to achieve Malcomess (2015) implies that Care Aims will not achieve this because it:

*“is a process driven target that will never deliver satisfaction for them or service users”*

and that further discussion is required prior to Care Aims training to identify different benefits such as effectiveness and safety. This suggests that Care Aims could never achieve some of the outcomes the managers wanted. It is of note that Malcomess comments (Malcomess, 2015) were written several years after Care Aims was implemented in the organisation. This perhaps is a reflection of Malcomess earlier comments that Care Aims is an evolving model which will:

*“continue to develop and grow as more and more practitioners use it in everyday practice”* (Malcomess, 2005b).

However all were at different stages of implementing Care Aims (table 6.3, p.90) and this may have influenced understanding of vision and the possibility of multiple visions being referred to e.g. the vision the overall purpose of the team and the vision for use of Care Aims in the organisation. Further exploration of how teams saw the overall vision for their team and the service they provided and fit of Care Aims with this would perhaps be beneficial. The lack of a consistent and single clear vision for implementing Care Aims by managers may also have been influential. The lack of a clearly articulated shared vision may have impacted on implementation as where implementation appears to have been more successful it was where Care Aims supported the team's rather than an organisational vision.

## **8.5 Leadership**

The role of the leaders and managers in supporting implementation has been documented by both Stansfield and Matthews (2014) and Roddam and Selfe (2009). In case studies 1 and 3 there was evidence to suggest that the team leaders had been involved in leading different aspects of Care Aims implementation and therefore integrated team working and of a clear vision for the future. In case study 2 it was reported that the team leader was keen for the team to continue using Care Aims in

spite of the team's reluctance but use of Care Aims did not appear to be aligned with how the team saw the vision for delivering the service.

In case studies 1 and 3 the teams appeared to have more than one team leader and the team leaders represented different professions within the team. In case study 2 there was just one team leader. From the small number of case studies it is difficult to ascertain whether it is a collective leadership model that positively influences Care Aims implementation or level of engagement. In case studies 1 and 3 team leaders responded to questionnaires and participated in interviews but the team leader in case study 2 did neither.

As described in section 7.7 where there is a mix of professionals in the leadership structure there appears to be greater team integration possibly due to the different professional voices feeling heard and understood suggesting support for the notion that leadership is hugely influential on culture (Kings Fund, 2015).

In section 8.3 it was suggested that Care Aims implementation had been more easily facilitated in the more integrated team. Holt et al (2010) argues that complex changes are more dependent on collective and coordinated actions of many interdependent individuals each of whom contributes to the implementation – collective leadership. This may be in part due to the increase in people within the team who are able to create the psychological safety that Schein (2010) describes for example by supporting individuals, providing coaching and positive role modelling.

Therefore it is possible that the more leadership is distributed and developed across a team the more Care Aims implementation will be facilitated.

## **8.6 Management of Change**

Each of the case studies appeared to suggest different attitudes towards implementing Care Aims (table 7.8, p.184). In case study 1 the team expressed dissatisfaction with their current ways of working. Whilst it would appear that Care Aims training exacerbated this further, there is evidence to suggest that the team were unhappy with how they were working and managing their caseloads prior to this: Lewin (1947 cited in Schein 2010) describes this creating disequilibrium as unfreezing. As described in section 6.5.6 Schein (2010) identified three components of unfreezing. The first component – disconfirming data appeared to only be present in case study 1:

*“We need to do something or else we are just going to sink. We can’t possibly carry on the way we are” (case study 1, AHP 1, p.5, line 27)*

*“..potentially you’re being dangerous. It’s a dangerous way to practice and I hadn’t appreciated that” (case study 1, Nurse 1, p.6, line 6).*

In case studies 2 and 3 the teams appeared to be quite happy with how they were working and did not appear to be expressing any dissatisfaction with how they were working prior to Care Aims implementation.

In case study 1 there appeared to be evidence suggesting that team members saw a connection between their disconfirming data and their vision for the service they wanted to deliver (the second component of Schein’s unfreezing process) i.e. how team members saw the team in the future and whether Care Aims was seen as an enabler for achieving their vision. Whilst case study 3 did not appear to have disconfirming data to motivate change they did view Care Aims as a way of improving the service they delivered and achieving their vision for the service. This appears to support the view that vision is also critical to creating motivation to change (Kotter, 1995; Schein, 2010; Gilbert et al, 2014). Another influencing factor is whether the change is valued which Weiner (2009) calls the change valence. This is different from the model of receptive context for change (Pettigrew et al, 1992). Weiner (2009) proposes that whilst it is possible to have a receptive context for change, the team/organisation may not be ready to change and the content of the change matters as much as the context. This would appear to be present in case study 2 and Care Aims was not seen as an enabler for improving the service. Developing readiness to change further, Holt et al (2010) describe four dimensions that influence an individual’s readiness to change:

- Feel the change is appropriate
- Believe management support the change
- Feel capable of making the change successful
- Believe the change is personally beneficial

Using this framework in case studies 1 and 3 there is evidence to support that teams felt the change was appropriate either because it would improve the current situation (case study 1) or it was consistent with how the team worked (case study 3). The team in case study 2 expressed concern that Care Aims was too difficult and did not support how the team worked. Both case studies 1 and 3 were early implementers of Care Aims and enjoyed lengthier and in-depth training and support from the organisation to

support implementation. This support could be perceived as indicative of management support for the change. Although in case study 3 there was some frustration expressed that Care Aims did not always influence how patients were prioritised and conflicted with commissioning priorities. In case study 2 team members received less training and also less post-training support and this may have been interpreted, along with the ambivalence of the team manager, as management not supporting the change. Linked to the training and consistent with Schein's theory of creating psychological safety (Schein, 2010) are team members feeling capable of making the change. In case study 1 implementation was slow and the team expressed the need for support from outside the team to help them. In both case studies 1 and 3 the team adapted their existing processes to work within the Care Aims approach whereas in case study 2 the team was reluctant to do this as they felt Care Aims did not improve on their current processes. Another difference between case study 1 and 3 was that the team in case study 3 felt empowered to make changes to processes whereas the team in case study 1 did not and acknowledged that progress had slowed because the support they had received from outside the team to help with this had stopped for a period of time as the facilitator was on an extended period of leave. Nurse 1 said:

*“we felt like we still needed someone to hold our hand”* (case study 1, nurse, p.5, line 3).

In case study 2 team members suggested they felt unsupported following training whereas in case study 3 the whole team was involved in implementation. In terms of personal benefits in case study 1 team members expressed that they felt that using Care Aims potentially kept them safe as current ways of working were unsafe but also gave them permission to say no and discharge patients. In case study 3 the ability to discharge patients who may previously have stayed on the caseload was also expressed as a benefit. Whereas in case study 2 Care Aims was perceived to not add any value and was considered as time consuming. Although case study 3 also reported training to be challenging this was in the context of a shared discussion to understand perspectives whereas in case study 2 Care Aims itself was considered to be subjective which appeared to be at odds with personal beliefs.

Herscovitch and Meyer (2002) argue that commitment to change is one of the most important factors in relation to staff support for change initiatives and tested a three level model. They found that individual commitment to change is a better predictor of behavioural support for change than organisational commitment. In both case studies 1 and 3, team members appeared to demonstrate evidence of affective commitment i.e.

they were keen to support Care Aims implementation as they believe it will be beneficial.

*“Care Aims helped”* (case study 1, Team questionnaire 2, question 6)

*“Saved time for me”* (case study 1, team questionnaire 5, question 7)

*“This will help me prioritise my caseload more effectively”* (case study 1, team questionnaire 4, question 7)

In case study 2, there appears to be evidence that whilst the team seem compliant i.e. attended training and started to use Care Aims for various aspects of the care pathway, they did not appear to show acceptance of the change or willingness to champion or embrace the change:

*“I felt it didn’t alter my thinking.... Care Aims was suspended for use in our service”* (case study 2, team questionnaire 1, questions 11 and 12)

In both case studies 2 and 3 it became apparent that level of training did appear to have a positive relationship with level of engagement and support for Care Aims.

Where teams were expected to maintain the same level of activity to manage caseload demands apparently without sufficient time and resource to support training and development, also appeared to impact on the success of implementation. The teams in both case studies 1 and 3 were early implementer and appeared to have been given significant time to attend training and then further development to support implementation, supporting the need for teams to have time together to consider the change (West et al, 2012). Teams that trained later such as the team in case study 2 and also new starters to the organisation received much less training and support. AHP 2 in case study 3 commented new staff:

*“do a whistle stop tour through that so I don’t think they get the opportunity to have that dawning like we did”* (p.4, line 6).

*“the people who’d been on longer training were probably more, I don’t know the right term, more up for it really and more involved in trying to get it to work”* (p. 9, line 3).

This may relate to what Schein (2010) describes as the creation of psychological safety by reducing the level of learner anxiety. By creating opportunities for shared discussion and learning this would help reduce feelings of competence, fit of Care Aims with team and professional identity. In both case studies 1 and 3 teams described coaching from either within the team or from outside the team, although in case study 1 progress slowed when the person leading this was absent for a period of time. In case study 3

there was also the presence of a Care Aims champion within the team AHP 2). In both case studies 1 and 3 the team leaders suggested they were being **l** to varying extents, positive role models for Care Aims. All these factors suggestive of creating psychological safety.

The shared team discussion particularly in case study 1 appeared to facilitate a better understanding of each other's professional cultures and promote consensus for future service delivery. For case study 2 the less intensive training and support appeared to have a significant effect on Care Aims implementation and also the opportunity for shared team discussion. This would appear to support the importance of creating time and space to understand new ways of working (West et al, 2012; Cameron et al, 2012) so that teams have time to work through cultural and professional issues, negate stereotypes and build mutual trust and respect.

Another explanation could also be that team members in case studies 1 and 3 felt more valued as they appeared to receive more in-depth training and better support afterwards. In both case studies 2 and 3 it was identified that those who received the longer training not only had a better understanding of Care Aims but were also more motivated to facilitate implementation.

Being supported to have the time to do this varied between the case studies. In both case studies 2 and 4 it was identified that when teams were particularly busy Care Aims was implemented less. Whether this was due to Care Aims being reported as time consuming initially or the lack of time to consolidate learning is unclear.

Costs in terms of training and time to learn new ways of working are well documented (Schein, 2010) and the acceptability of these costs may be dependent on how receptive and ready the context is for the change taking place. Case study 2 was potentially the least receptive and ready whereas case study 3 was the most.

In both case studies 2 and 3 there was recognition that working in a different way such as to implement Care Aims, i.e. working in an integrated way; was time consuming and therefore incurs a financial cost as activity is negatively affected. However case study 2 and 3 expressed this in different ways. In case study 2 the focus was on Care Aims being time consuming and a suggestion of frustration that capacity was affected. In Case study 3 there appears to be regret that not all the team could access the same level of training and that Care Aims was not fully utilised when the team was busy. In Case Study 3 there appeared to be an acceptance that it was inevitable that changing

practices and ways of working would affect capacity unlike in case study 2 where this impact appeared to be unacceptable.

One possible explanation for the differences in how the same professions interacted in each case study may relate to the receptive context for change (Pettigrew et al, 1992). Both Newton et al (2003) and Stetler et al (2009) found that a key factor was the people leading the change which strongly influenced implementation. In case studies 1 and 3 there was evidence that the team leaders had been involved in leading different aspects of Care Aims implementation and therefore been able to facilitate and champion integrated team working and promote a clear vision for the future. In case study 2 it was reported that the team leader was keen for the team to continue using Care Aims in spite of the team's reluctance (AHP 1, p.4, line 14) but use of Care aims did not appear to align to how the team saw the vision for delivering the service. This suggests that the focus could have been on the change rather than the goal (Fuda, 2009).

A receptive context for change was identified as a global theme from the manager's interviews. This suggested initial support for Care Aims implementation. The second global theme regarding the outcomes from Care Aims which suggested that Care Aims had not achieved all the anticipated outcomes may also have influenced how the teams in the case studies perceived management support. The teams in case studies 1 and 3 were early implementers and as suggested earlier appear to have experienced greater management support. At a similar time to when the managers were starting to understand and explore the impact of Care Aims and realising that it was not meeting all their expectations, case study 2 were starting to implement Care Aims. Their perception of reduced management support and also the narrative from case study 3 that there were conflicting priorities and not always feeling supported by managers may reflect the change in support by some of the managers for Care Aims.

The impact of factors such as vision, leadership, team and professional culture on creating the motivation to change is significant. However also essential were training and ongoing leadership support and positive feedback to maintain the motivation to change. All these factors contributing and influencing the change journey (figure 8.1, p.215).

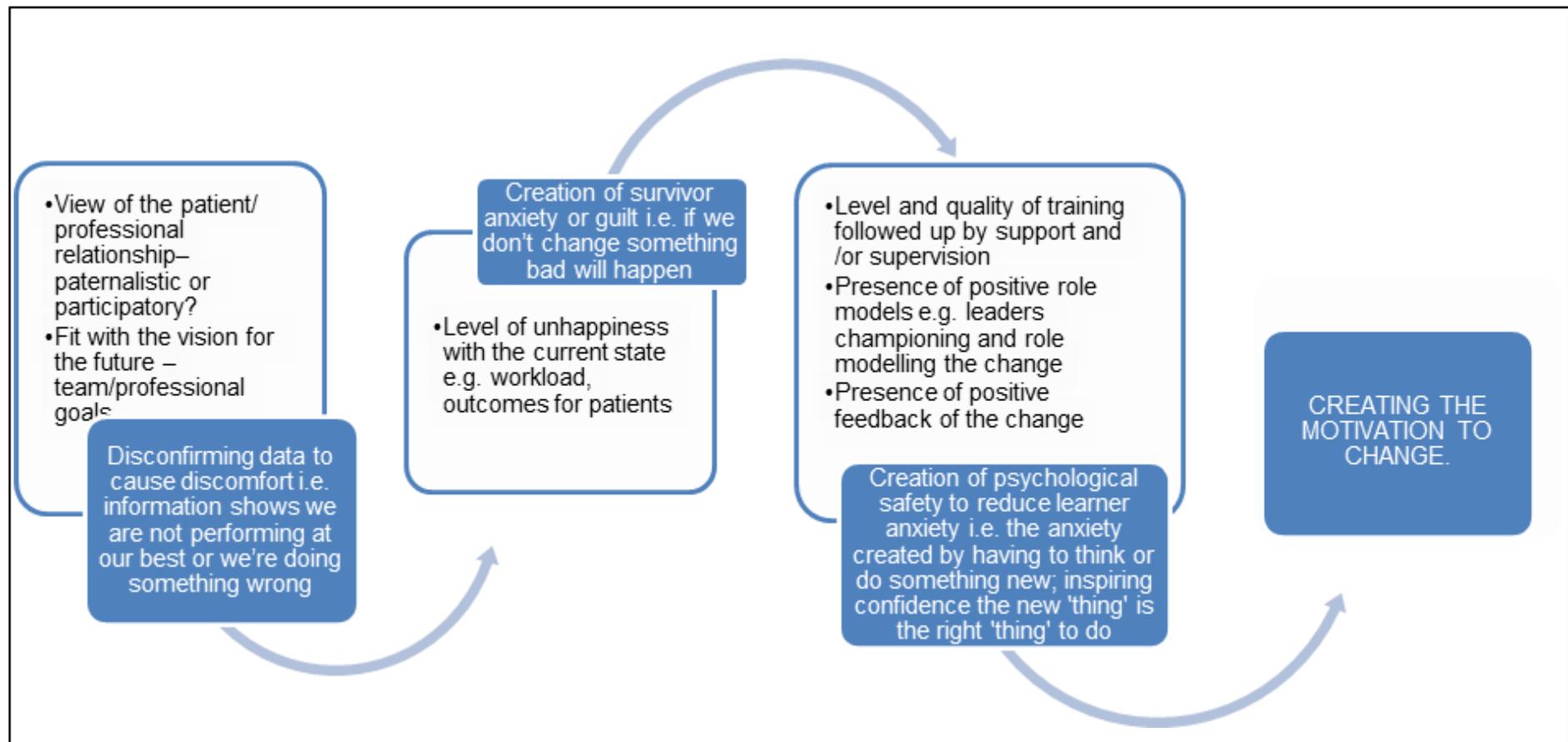


Figure 8.1 Creating the motivation to change

Although Gleicher's (1986) work preceded that of Schein (2010), Herscovitch and Meyer (2002) and Weiner (2009), his formula for change summarises succinctly the likely success of change:

*Change is unlikely unless  $A+B+C>D$  where:*

*A=individual or groups level of satisfaction with things as they are now*

*B= Individual or groups shared vision of a better future*

*C= the existence of an acceptable first step*

*D= the costs to the individual or group*

## **8.7 Professional Culture**

Professional culture appears to have impacted in several ways: the acceptability and level of change required by the professional in relation to their predominant model of care; how they view other professionals; and the value and importance placed on professional autonomy. The themes relating to professional culture are shown in table 7.9 (p.186).

In both case studies 1 and 3 team members described how during Care Aims training they had recognised that not all clinicians, even those from the same professional grouping such as AHPs, practised in the same way and had different professional cultures. In case study 3 AHP 1 gave the example about podiatry:

*"they only thought about what they were doing, about feet, there was nothing else about that person in that goal. It was literally quite a, you know, this is what I'm going to do, this is how it's going to be solved"* (AHP 1, p.3, line 10).

Other aspects of professional culture expressed were in relation to autonomy and how professionals related to each other. Similar to team type where the greater the level of integration the less professional autonomy there is, the further away from a biomedical model of care the practitioner is, professional autonomy also decreases. Traditionally particular models of care appear to have been more dominant in some professions rather than others e.g. doctors and a biomedical model of care. As suggested earlier implementation appeared to be easier in those teams whose culture was closest to Care Aims i.e. where potentially least change was required. This may be similar for professional culture where Care Aims is more readily accepted where the dominant professional culture is closest to that of Care Aims. In the organisation which the case studies took place; Care Aims had been introduced primarily to nursing and AHP teams. Manager 2 reflected:

*“we’ve shied away from medics and we’ve shied away from psychologists with Care Aims as an approach”* (p.8, line 20).

Whilst the rationale for this was not explored further it may be that the level of change required from some professions such as doctors was felt to be too great at the time. Although manager 2 did not rule out implementing Care Aims with doctors and psychologists, it was felt that a hybrid model may be required.

Another aspect of professional culture is how research and evidence based practice is viewed. This also relates to model of care. For example Hall (2005) found that nurses favoured experiential and qualitative information doctors preferred more scientific quantitative evidence. Care Aims uses effectiveness rather than efficacy to frame the evidence base again suggesting a move away from a medical model of care.

In the literature review and other studies (Stansfield and Matthews, 2014; Waterworth et al, 2015) a lack of published literature relating to Care Aims was also identified. In case study 2 AHP 1 repeatedly identified Care Aims as subjective. For professions where a medical model of practice dominates this apparent lack of evidence base may further compound successful implementation of Care Aims. For example in case study 2 Care Aims several comments from AHP 1 could be indicative of the tensions between a biomedical model and Care Aims: several times AHP 1 refers to the subjective nature of Care Aims and repeated use of the word justify.

How professionals relate to each other will also influence team type and potentially the level of integration. Care Aims asks the clinician to consider *“am I the best person to offer this help”* (Malcomess, 2015) how a clinician views other professions or other people working with the patient is central. In case study 1 Nurse 1 describes overhearing a conversation between two clinicians about a clinician from a different profession which was quite alien to her because she felt:

*“We need to trust our colleagues. If we trust our colleagues and we work together we can have the confidence to discharge our duty of care to other clinicians”* (p.7, line 30).

Similarly in case studies 1 and 3 where Care Aims appeared to be more successfully implemented or have potential for successful implementation, it was reported that the whole team had completed the training and the team had development time together to enable the debate and exploration of aspects of professional culture. This would appear consistent with the findings of West et al (2012) and Cameron et al (2012) that it was important for teams to have time to explore and work through differences and to

build trust and respect. These teams, case studies 1 and 3 had also involved band 3 and 4 staff in Care Aims training which did not appear to have happened in case study 2.

Although Care Aims has potential to create a common language across different professions, Smith et al (2016) identified that a common language did not automatically erase knowledge boundaries and that individuals may interpret the shared language and communication differently due to different perceptions of reality. In case study 2 AHP 1 notes:

*“it’s got its own language, it’s got its own terminology”* (AHP 1, p.4, line 23).

Manager 3 said:

*“there is still something about the Care Aims language not necessarily being the language that others outside of this organisation would particularly understand”* (manager 3, p.4, line 16).

In case study 1 this appeared to have been explored further by the team with the acknowledgement that implementing Care Aims required greater change by some professions compared to others. These findings suggest that Care Aims may be more easily implemented by some professionals than others.

## **8.8 Team Culture and Climate**

Care Aims is promoted as being a solution where:

*“there are mixed messages between the stated aims of your organisation and the reality of how processes are applied...team’s morale is low....team is dysfunctional”* (Malcomess, 2015).

These are all suggestive of a negative team climate. As described in section 7.10 there did appear to be a relationship between team climate, social desirability score and level of integration. There also appears to be a similar relationship between team climate, social desirability score and implementation of Care Aims. However it is unclear whether the relationship is between team climate and Care Aims implementation or level of team integration and Care Aims implementation or a combination of all three. As the three teams were at different stages of implementation and team climate and culture had not been assessed prior to the introduction of Care Aims it is not possible

to explore or identify whether team climate changed as a result of introducing Care Aims. No literature could be found to support this claim either. This could be an area for future research.

### **8.9 Staff Roles and Responsibilities**

Similar to the findings of Stansfield and Matthews (2014) Care Aims has facilitated understanding of duty of care and clinical decision making in case studies 1 and 3. Particularly in case study team members expressed how this had helped them better define and articulate their role and responsibilities. However concern was also expressed about creating artificial barriers:

*“If we interpret our duty of care wrongly we are creating artificial black holes....somebody will say this isn’t my role” (case study 1, Nurse 1, p.8, line 23).*

The literature (table 2.4, p.31) frequently identifies role and responsibilities as both a facilitator and barrier to integrated team working. This suggests that Care Aims has the potential to facilitate integrated team working by helping team members clarify their role and responsibilities but if poorly managed could become a barrier. The interdependency with leadership and vision is apparent.

The level of involvement of band 3 and 4 staff in Care Aims training differed between the case studies. In case study three all the team had attended the Care Aims training and this had been welcomed by the rehabilitation assistants even though at the time they had not thought they would. Whereas in case study 2 the assistants did not receive training and were subsequently not involved in discussions about implementing Care Aims. This may be a reflection of the apparent dominance of a biomedical model of care in case study 2. In a biomedical model hierarchical working is the norm (Pearson et al, 2003). In contrast in case study 3 the team who appear the most integrated and where band 3 and 4 staff were included in training, hierarchical working emerged as a theme. The interdependency of staff role and relationship with approach to care can also be seen. In case study 3 where assistants had been more involved in Care Aims training and development, implementation had been more successful compared to case study 2 where they had not been. In case study 1 there was only one assistant and they joined the team after Care Aims training had taken place. It would appear that involvement contributes to successful implementation alongside other factors discussed in this section. However the decision to include assistants in

training and implementation may be more a reflection on approach to care and team culture and climate.

## 8.10 Role and Relationship with Patients

Malcomess (2015) describes Care Aims as a:

*“person-centred rather than problem-centred approach. It requires practitioners to ask “can I help this change the impact of this problem on this person’s life and am I the best person to offer this help?” rather than “what is wrong and can I change the problem”.*

The themes relating to the perceived role of patients and the relationship between staff and patients are shown in table 7.15 (p.198). For example in case studies 1 and 3 the patient appeared to be seen or was wanted to be included by the team as an equal. In case study 2 this appeared not to be the case. There appeared to be more of a biomedical model of working where the clinician was suggested to be superior to the patient. As Wade (2004) identifies, the biomedical model includes the beliefs that:

*“the patient is a victim of circumstance with little or no responsibility for the presence or cause of the illness; the patient is a passive recipient of treatment, although co-operation is expected” (p.329).*

A key part of Care Aims appears to require the ability to focus on impact which requires greater involvement of the patient rather than problem solving. In both case studies 1 and 3 the need for patients to participate and take part in goal setting and treatment was articulated:

*“equally the patient has to participate” (case study 1, AHP 1, p.6, line 14).*

*“it was almost like a contract really. This is what we would provide then what you will do to help” (case study 3, AHP 2, p.7, line 10)*

Use of functional goals in case study 3 was described as being integral to how the team worked with patients having an active role in care planning. Whereas in case study 2 the example was given of a therapy led goal:

*“Mr Jones will start to walk, try to walk 5 metres per day” (AHP 1, p. 5, line 24).*

Perception of patient role and responsibilities appears to impact on successful implementation of Care Aims. However as discussed in section 7.12 perceptions of

patient role and responsibilities also appears to be closely related to approach to care and professional cultures. In section 8.7 it was recognised that Care Aims may be more difficult for some professions to implement than others and this could also impact on their ability to have a different relationship with patients in line with the Care Aims approach. The likely success of this change happening expressed in Gleicher's (1986 in Martin and Rogers, 2004) formula (section 8.6). Again the interdependency between the different factors on successful implementation of Care Aims emerging.

### **8.11 Philosophy and Approach to Care**

The approach the teams had prior to introducing Care Aims appeared to vary between teams as discussed in section 7.13. The dominant philosophy/approach to care identified in each case study derived from the interview and questionnaire data (table 7.16, p.200).

In this study, one way philosophy of care appeared to be expressed was by how team members described their relationship with patients and the way in which the goals of therapy/interventions were developed and articulated. This is discussed in section 8.10. The model of care in case study 3 prior to implementation appeared to be compatible with Care Aims. Whilst it was less so in case study 1 the team felt Care Aims could help them (figure 6.10, p.115). However in case study 2 their appeared to be a more biomedical model of working which would seem to less reconcilable with Care Aims and potentially require a greater change in how they think and provide care. Adopting Care Aims for the team in case study 2 may have represented a huge paradigm shift as they were potentially being asked to change their team and/or professional culture following a training programme. Conversely in case study 3 the team's philosophy of care appears closer to that of Care Aims and the Care Aims approach more readily accepted.

In the previous section discussing professional culture (section 8.7), staff roles and responsibilities (section 8.9) and patient role and responsibilities (section 8.10) approach and philosophy to care was a recurrent theme: each of these factors an expression of philosophy and approach to care. Similar to professional culture particularly, Care Aims may be more easily implemented in some approaches to care than others. In this study, implementation appears to be more successful in teams with the least biomedical approach to care. In the teams with the least biomedical approach

to care the level of change required was also less which again may have impacted on implementation.

## **8.12 Summary**

This chapter has identified factors which appear to influence the success and ease of Care Aims implementation. The interdependency between the factors is apparent, as is their shared impact on implementation and acceptance of Care Aims.

Whilst the case studies appeared to be of comparable service type to those in the published studies, success of Care Aims implementation varied. The impact of commissioning whilst important did not appear to be a significant limiting factor. The level of team integration did appear to correlate with the success of implementation. This may be related to the less change being required by the team to put Care Aims into practice. Similarly when professional culture, relationship with patients and overall approach to care was least aligned to the biomedical paradigm Care Aims again appeared to be more successfully implemented. This could be due to less change being required.

Closely related also was alignment of Care Aims to vision. Implementation appeared more successful where Care Aims was viewed as facilitating achievement of vision and also where implementation of Care Aims was not the vision itself.

There also appears to be a relationship between team climate and implementation. Surprisingly, an overly positive social desirability score and potentially more positive team climate appeared to be associated with less successful implementation. It is unclear whether team climate affected implementation or implementation affected team climate.

Caution should be applied as the findings are based on four case studies with relatively small numbers of respondents. These findings by exploring and comparing the implementation and use of Care Aims in several integrated teams appear to have identified a range of factors which could facilitate more successful implementation of Care Aims. This will add to the body of literature regarding Care Aims and offers a new perspective by exploring and comparing implementation in several case studies.

## **CHAPTER 9**

### **IMPLICATIONS FOR PRACTICE, RESEARCH AND POLICY**

#### **9.1 Introduction**

This chapter draws together the results and conclusions from this study and offers an insight regarding how the findings contribute to the wider knowledge base. This exploratory study aimed to explore the effect of culture and context on integrated team working for AHPs in community settings using case studies. The case studies used qualitative methods to collect data and two standardised questionnaires to provide comparative contextual information about team climate and culture.

The overall findings of the individual case studies and cross case analyses are discussed in the context of the literature. These are:

- the cross case analysis and development of a framework to support cross case analysis
- patient's perspective
- factors supporting the implementation of care aims

#### **9.2 Summarising the Literature Review**

One of the early challenges of this study and supported by the literature review was the inconsistent use of terminology particularly to describe team types, integration and team working. The literature review also explored several different models of integration but found few examples of case studies to demonstrate them in practice. The role of the patient was consistently identified in the literature as being central to the integration agenda. Whilst the models varied there did appear to be consensus about the features of integration that supported better outcomes for service users. However the majority of these appeared to be from the perspective of staff and not service users. There also appeared to be a lack of literature specifically exploring type of service model and approach to care.

The literature review identified that few studies appeared to involve AHPs with the reasons for this unclear from the literature. Many of the published case studies did not appear to identify clearly which professions were present in the teams. The

inconsistent use of terminology may have also contributed in that there may be examples of AHPs working in integrated teams but not identified or it was not acknowledged that these teams were integrated.

The barriers and facilitators to integrated team working and provision of integrated care are well documented. Many of the facilitators and barriers to integrated team working identified in the literature appeared to be similar to dimensions of culture such as leadership, roles and responsibilities. Yet there appeared to be few studies specifically exploring team culture and climate particularly with standardised assessment tools. This may offer an explanation as to why the reported barriers and facilitators have changed or improved much over time. The impact of professional culture was also a common theme in the literature regarding integration and team work.

More recently the importance of context has emerged with increasingly more literature stating that there is no one single solution or model for integrated team working or provision of integrated care. Yet the barriers and facilitators appear to consistently emerge again suggesting the importance of understanding culture, climate and context.

In summary, the literature review explored how the integration agenda had evolved with an apparent recognition of the continuum it could cover. Definitions and inconsistent use of language continue to be challenging and perhaps also limit understanding and further progress in this area. The literature review explored how many of the factors affecting integrated team working are similar to those for team working. The breadth and variety of professions working in an integrated team may magnify potential differences in culture and practice.

### **9.3 The Cross Case Analysis and Development of a Framework to Support Cross Case Analysis**

The cross case analysis of the case studies identified ten inter-related categories present in varying degrees in each of the case studies. The ten categories enabled a detailed descriptive comparison of the case studies. The findings explored the differences and potential reasons why some of the teams in the case studies were able to work in a more integrated way than others. However these are context specific. The teams in this case study were all from the same organisation and none of the teams included medical or social care staff.

In this study it would appear that the service provided by the teams in each case study all had potential to be integrated yet the extent to which integration had occurred varied. In each case study team members reported differently what their perception of team type was. It is unclear whether team members did have different perceptions of team type or whether it was inconsistent use and interpretation of terminology similar to that identified in the literature. For example when team members used multi-professional and multidisciplinary did they mean the same team type.

In this study the model of leadership appeared to influence the effectiveness and extent of integrated team working with the teams with shared leadership appearing to have greater levels of integration. The role of the leader in integrated care and leading integrated teams appears to be well documented as is the influence of leadership on culture (Kings Fund, 2015). It includes the importance of having the right person in charge, with a clear vision but also understanding the potential for their own professional culture and/or personal interests to influence direction and progress. The importance of team members being involved in development of integrated teams and in change management generally is well documented. However there appeared to be little literature exploring the impact of collective or shared leadership on integrated team working. Caution should be applied to these findings though as the numbers were small and may relate more to the characteristics of the individuals than overall culture.

Exploration of the role of collective leadership in integrated teams is recommended as an area for future research. A longitudinal study exploring leadership over a period of time in an integrated is also an area for future research. In particular in case study 3 a longitudinal study to explore team climate and functioning where the initial findings appeared potentially contradictory: the presence of shared leadership and hierarchy both appeared to influence team functioning. The literature suggests that a hierarchical way of working is inconsistent with shared leadership (West et al, 2014). Although a longitudinal study may be more challenging given the amount of change NHS teams and services appear to be subjected to.

Change management was also a common theme in all the case studies. The findings appeared to support aspects of Schein's theory of managed change (Schein, 2010) and Holt et al's dimensions of readiness to change (Holt et al, 2010). Training also appeared significant in these case studies. This is consistent with change management theory (Schein, 2010) and also with the factors supporting integrated team working. One of the strengths of this study was that the case studies were all from the same organisation and all were implementing Care Aims.

Closely related is understanding and belief in vision. Both case studies 1 and 3 appeared to articulate a shared vision for integrated team working and provision of integrated care. However this was inconsistent with the reported TCI results. One of the strengths of this study is the use of both standardised assessment tools and qualitative methods to triangulate data. Whereas use of one approach only could potentially bias interpretation of the data.

The findings from the cross case analysis for professional culture appeared to be similar to those in the literature for integrated working. Professional culture appears to impact on approach to care, level of autonomy and how professions view each other hierarchically. Professions with a more biomedical approach to care may find it more difficult to work in an integrated way. Closely related to this is level and value placed on professional autonomy: level of professional autonomy decreasing as extent of integrated teamworking increases. In this study the relationship between different AHPs and between AHPs and nurses was able to be explored and documented. This does not appear to be readily found in the literature possibly due to the lack of detail as previously mentioned in published case studies. In this study the more integrated teams appeared to demonstrate greater blurring of role boundaries although this was mainly between the AHPs. This may be related to how the AHPs viewed other professions.

Team culture and climate appeared to impact on integrated team working. There appeared to be little published literature describing the use of standardised assessment tools to measure team culture and climate in teams involving AHPs. Again this may be due to the lack of detail in published case studies. The use of the OCAI and TCI provided contextual background and helped facilitate cross case analysis of some aspects. Surprisingly the most integrated teams not having the more positive team climate results. The social desirability scores appearing to be more significant than the team climate result itself. Further research in this area is recommended.

One of the areas where the teams appeared to differ significantly seemed to be how they viewed their relationship with patients. In both case studies 1 and 3 patients were viewed more as partners in care and were seen as having an active role in both decision making and delivery of care. In case study 2 this was less so with the staff appearing to report a more hierarchical relationship with patients, possibly consistent with a biomedical approach to care. However in case study 2 the only case study with several patient responses to questionnaires, patient feedback appeared positive. This was the case study where the team appeared to provide the least integrated care.

Whilst it is recognised in the literature that patients in this age group may be overly positive it does suggest that further exploration of whether services actively need to be integrated to provide effective care to patients. Further exploration of what integrated working actually means for patients would be beneficial.

Professional culture and relationship with patients are expressions of philosophy and approach to care. The findings in this thesis appear to support previous studies that more integrated working is related to a move away from a biomedical approach to care.

The cross case analysis suggested mixed support for Leutz's laws (table 2.2, p.15) with some appearing more influential than others. Whilst there was limited evidence in relation to integration being targeted at certain cohorts of patients or integration costing before it paid, there was stronger evidence to support the influence of team dynamics and leadership on integrated working and therefore the provision of integrated care. The addition of a further law may go some way to addressing this:

***“You can integrate all of the teams for some of the people, some of the teams for all of the people, but you can't integrate all of the teams for all of the people.”***

#### **9.4 Use of a Minimum Dataset to Support Cross Case Analysis**

One of the strengths of this study and where it differs from existing published literature is that it provides a detailed documentary comparative analysis of integrated teams. In chapter 4 it was identified that one of objectives of this study was to compare and contrast the case studies in this study with other published case studies. This proved challenging, with similar findings to those of Nancarrow et al (2013) in that many studies lacked detail in terms of context, team roles and processes to enable comparisons to be made. This may be due to Yin's observation (2014) that the analysis of case study evidence is one of the least developed aspects of case study research.

It is recommended that use of a minimum data set would enable better comparison of case studies describing provision of integrated care and integrated team working. A minimum dataset based on the nine categories that emerged in the cross case analysis would enable more detailed comparison of case studies. It may also help overcome some of the confusion that inconsistent use of terminology has created by providing a richer narrative to facilitate understanding. Table 9.1 (p.229) suggests what such a

dataset and framework could look like. It also provides ideas for how data could be collected and potential measures.

Table 9.1 Suggested minimum dataset to support cross case analysis

| <b>Factor</b>                                    | <b>Suggested measure/data included</b>   | <b>Suggested methods of data collection</b>  |
|--|--|--|
| <b>Service type</b>                              | <ul style="list-style-type: none"> <li>• Type of service e.g. universal, targeted, specialist</li> <li>• Population aimed at including age range, acute or long term conditions</li> <li>• Setting e.g. community, hospital</li> <li>• Size of service</li> <li>• Access to service</li> </ul>                               | <ul style="list-style-type: none"> <li>• Collection of documentary evidence e.g. referral form, service information leaflet</li> <li>• Staff interview/questionnaire</li> </ul>  |
| <b>Team type</b>                                 | <ul style="list-style-type: none"> <li>• Several definitions and models of team type available in the literature e.g. Boon et al (2004), Thylefors et al (2005)</li> <li>• Staff perception of team type</li> <li>• Researcher deduced perception of team type</li> <li>• Professions and numbers of each in team</li> </ul> | <ul style="list-style-type: none"> <li>• Provide detailed definition of terminology used - Specify source in literature</li> <li>• Staff perception of team type – interview/questionnaire</li> <li>• Perception of team type deduced from staff responses to questions about how team work in terms of allocating work, undertaking assessments and providing care</li> </ul> |
| <b>Shared understanding and belief in vision</b> | <ul style="list-style-type: none"> <li>• Standardised team climate assessment measure e.g. TCI</li> <li>• Staff perception of aim of team/service</li> </ul>   | <ul style="list-style-type: none"> <li>• Use of standardised assessment tool e.g. TCI</li> <li>• Staff questionnaire/interview – free text</li> </ul>  |
| <b>Team culture and climate</b>                  | <ul style="list-style-type: none"> <li>• Standardised assessment tools measuring team climate and cultural types or aspects of culture e.g. TCI, OCAI</li> </ul>   | <ul style="list-style-type: none"> <li>• Use of standardised assessment tools</li> <li>• Supplement assessment tools with narrative from team members re how team work together, communicate collected from interviews/questionnaires using open ended questions</li> </ul>  |
| <b>Factor</b>                                    | <ul style="list-style-type: none"> <li>• Suggested measure/data included</li> </ul>  | <ul style="list-style-type: none"> <li>• Suggested methods of data collection</li> </ul>   |
| <b>Leadership</b>                                | <ul style="list-style-type: none"> <li>• Number of leads</li> <li>• Profession of lead(s)</li> <li>• Whether operational and/or clinical leads</li> <li>• Length of time in role</li> </ul>  | <ul style="list-style-type: none"> <li>• Staff questionnaire/interview</li> </ul>  |
| <b>Professional culture</b>                      | <ul style="list-style-type: none"> <li>• Range and number of professions in team</li> <li>• How different professions in team view each other</li> <li>• How professions in team interact with each other</li> <li>•</li> </ul>  | <ul style="list-style-type: none"> <li>• Questionnaire/interview to staff and patients – open ended descriptive data</li> </ul>  |

| <b>Factor</b>                         | <b>Suggested measure/data included</b>   | <b>Suggested methods of data collection</b>  |
|---------------------------------------|--|--|
| <b>Staff roles and relationships</b>  | <ul style="list-style-type: none"> <li>• Skill mix in team</li> <li>• Use of extended roles</li> </ul>   | <ul style="list-style-type: none"> <li>• Explore how staff assess, plan and deliver care e.g. goal setting.</li> <li>• Record keeping – use of profession specific or shared clinical records</li> <li>• Staff and patient questionnaires/interviews</li> <li>• Review of documentary evidence such as clinical records</li> </ul> |
| <b>Patient role and relationships</b> | <ul style="list-style-type: none"> <li>• Extent to which patient is involved in planning and delivery of care e.g. how goals are agreed</li> </ul> | <ul style="list-style-type: none"> <li>• Explore how staff assess, plan and deliver care e.g. goal setting.</li> <li>• Record keeping – use of profession specific or shared clinical records</li> </ul>   |
| <b>Model and philosophy of care</b>   | <ul style="list-style-type: none"> <li>• Level of clinical and professional autonomy</li> </ul>  | <ul style="list-style-type: none"> <li>• Either direct questions to staff or deduced from how staff plan, assess and deliver care and relationships with each other and with patients</li> </ul>   |

## 9.5 Implementing Care Aims

Whilst this study did aim to investigate Care Aims it was not part of the original objectives of this study to explore the conditions or contexts that were more favourable to the implementation of Care Aims. However during the overall cross case analysis it became apparent that there were themes emerging that appeared to relate specifically to Care Aims implementation. These are described in detail in chapter 8.

The categories that emerged enabled a detailed descriptive comparison of the case studies. The findings explored the differences and potential reasons why some of the teams in the case studies appeared to be able to implement Care Aims more easily than others. However these are context specific. As identified earlier the teams in this case study were all from the same organisation and none of the teams included medical or social care staff.

It is recommended that use of a framework would enable teams considering implementation of Care Aims to explore the current culture and context in which they are working. This would potentially help identification and understanding of those areas which may need greater attention and support to facilitate successful implementation.

A potential framework developed from the finding of the cross case analysis is shown in table 9.2 (p.232). However caution should be applied as the framework was developed from specific contexts. An area for further research could be the exploration and application of the framework in different contexts.

Table 9.2 Factors influencing implementation of Care Aims

| Ease of Care Aims implementation and sustainability | More difficult to implement and sustain use of Care Aims  | Easier implementation and embedding of Care Aims in practice   |
|---|---|--|
| <b>Service type</b>                                 | Prescriptive, clearly defined prioritisation criteria based on condition and/or place of discharge  | Less clearly defined and/or at clinician decides based on clinical risk and clinical need  |
| <b>Team type</b>                                    | Inter-professional /multidisciplinary   | Uni-professional or integrated team  |
| <b>Vision</b>                                       | Care Aims not seen as an enabler to achieving team vision or Care Aims is perceived as the end point<br><br>No clear vision for service or clear vision for service and team do not feel Care Aims will facilitate this             | Care Aims is seen as facilitating achievement of team vision<br><br>Clear team vision  |
| <b>Leadership</b>                                   | One leader  | Collective leadership  |
| <b>Management of change</b>                         | No clear reason for change perceived by team<br><br>Expected to maintain same or increased level of service capacity to manage demand, available training and development time limited<br><br>High level of change required overall | Team want to change how they work<br><br>Reduced capacity expected with implementation and planned for<br><br>Low level of change required overall |
| <b>Team culture and climate</b>                     | Overly positive team climate/high social desirability score   | Positive team climate  |

| <b>Ease of Care Aims implementation and sustainability</b> | <b>More difficult to implement and sustain use of Care Aims</b>  <b>Easier implementation and embedding of Care Aims in practice</b> |  |
|--|--|--|
| <b>Staff roles and relationships</b>                       | Clear inter-professional hierarchy   |  View other professionals as equals  |
| <b>Professional culture</b>                                | Autonomy highly valued<br>Dominant biomedical approach to care traditionally   |  Accepting of reduced practitioner autonomy<br>Biomedical approach to care not dominant traditionally            |
| <b>Role and relationship with patients</b>                 | Paternalistic relationship with patient  |  Patients as partners in care  |
| <b>Approach to care</b>                                    | Biomedical model of care<br>Problem solving orientated goals led by clinician  |  Emphasis on whole person, diversity of healthcare philosophies<br>Impact focussed/ functional/ led by patient |

### 9.6 Application of Framework to the Case Studies

When the framework is applied to case studies 1, 2 and 3 (table 9.3, p.235) it can be seen that implementation of Care Aims was likely to be more difficult in case study 2 compared to case studies 1 and 3. Case study 4 is more difficult to judge as there was much less evidence to explore due to the low response rate. Leadership and commissioning arrangements were the only two areas where it was possible to identify where on the spectrum case study 4 were.

Consideration of the framework as part of the planning and preparatory work for Care Aims implementation may have helped identify which teams may have benefited from additional support and training to help facilitate Care Aims implementation. Alternatively

it may have led to the organisation selecting teams for implementation differently in order to evaluate the value of Care Aims to the organisation and of the benefits for service users.

Table 9.3 Application of factors affecting Care Aims implementation to the case studies

|   | Perception of where teams in each of the case studies is on the spectrum |              |  |  |              |
|---|--|--------------|--|--|--------------|
| Ease of Care Aims implementation and sustainability | More difficult to implement and sustain use of Care Aims                 |              | Middle of spectrum or no/little evidence | Easier implementation and embedding of Care Aims in practice |              |
|   | Closer to this end of spectrum   |              |  | Closer to this end of spectrum                               |              |
| Service type  | Case study 1   | Case study 2 | Case study 3                             | Case study 4   |              |
| Team type   | Case study 3   | Case study 1 | Case study 2                             | Case study 4   |              |
| Vision  | Case study 1   |              | Case study 2                             | Case study 3   | Case study 4 |
| Leadership  | Case study 1   | Case study 2 | Case study 3                             | Case study 3   | Case study 4 |
| Management of change                                | Case study 1   |              | Case study 2                             | Case study 3   | Case study 4 |
| Team culture and climate                            | Case study 1   |              | Case study 2                             | Case study 3   | Case study 4 |
| Staff roles and relationships                       | Case study 1   |              | Case study 2                             | Case study 3   | Case study 4 |
| Professional culture                                | Case study 1   |              | Case study 2                             | Case study 3   | Case study 4 |
| Role and relationship with patients                 | Case study 1   |              | Case study 2                             | Case study 3   | Case study 4 |
| Approach to care                                    | Case study 1   |              | Case study 2                             | Case study 3   | Case study 4 |

Key: Case study 1 Case study 2 Case study 3 Case study 4

Possibly the most influential factor which appears as a recurrent theme in this study is the potential impact the current model of care on the way the team and individual professions practice.

However caution should be applied as the findings are based on 4 case studies and are context specific. An area for further research would be to explore Care Aims implementation with more teams in the same organisation and with comparable and different teams in other organisations.

## **9.7 Limitations of This Study**

### **9.7.1 Method**

The inclusion criteria for this study were quite specific and limited the number of teams within the organisation that could be approached. At the time of setting up the study and data collection the organisation was undergoing a period of significant change. This limited which teams could be included as it was felt a team undergoing restructure would bias the results. Whilst teams may not have directly been part of a restructure, at the time of data collection, the organisation was undergoing merger with several other organisations and this may have impacted on the results. It may also partially explain the apparent change in managerial support and level of training provided as the lead organisation in the merger was not using Care Aims at the time of the merger. Repeating the study at a time when the organisation is more stable may produce different results.

Data collection for case study 4 took place approximately 12 months after case studies 1, 2 and 3 and following further change at organisational level. This may have impacted on the response rates. Also the fourth case study involved a team who have been from a different organisation from the other three case studies and prior to the organisational merger. It is possible this also influenced response rates.

The findings may also have been influenced by how long they had been using Care Aims for. Case study 2 had been using Care Aims for less time than case studies 1 and 3 and Care Aims implementation appeared to have been less successful in case study 2. However data was collected approximately the same time following initial Care Aims training in both case studies 1 and 2 with different results.

Whilst use of the critical incident technique provided specific examples of how teams worked and used Care Aims, it became apparent during several interviews that team members found it difficult to give specific scenarios. Whether this was due to a perception of potentially breaching patient confidentiality is unclear. However with repeated prompts most respondents were able to give more detailed answers. Some of the Care Aims questionnaires also provided very brief responses rather than detailed specific answers which limited the richness of data. Again it is unclear whether this is in response to a perception of breaching patient confidentiality or whether time constraints limited responses is unclear.

Generally responses to the TCI were good. However this was not always the case for the OCAI with some respondents not fully following the instructions in terms of how the 100 points were allocated across the four boxes. This potentially biased some responses. In all cases there were insufficient responses to meet the 75% minimum response rate required for the TCI as recommended by Anderson and West (1996). Therefore these responses can only give an indication of team climate.

The response rate to the Care Aims questionnaires varied greatly across the case studies. The best response rates were from teams where the team leads were known to myself and this may have influenced the response rate. This was particularly the case for case study 4 where the team and team leader were not known to me at all prior to the study.

The pilot study had suggested the structure of the research design was robust. However providing teams with three questionnaires to complete may have influenced the response rate. It also became clear that in some cases team members had selected which of the questionnaires they wished to complete and not completed them all. The response rate may have been improved by either asking team members to complete some or all of the questionnaires at a team meeting or staggering when the questionnaires were given to the team over a longer period of time. However this could lead to different people completing different questionnaires dependent on the turnover in the team and the time period over which the questionnaires are distributed.

The interviews were felt to provide much richer data than the Care Aims questionnaires. An alternative design may have been to use the TCI and OCAI and approach team members to take part in interviews.

As previously mentioned and consistent with other studies exploring integrated team working and integrated care, there was a poor response from patients. This may be due to patient's not being approached directly by the researcher but by team members. Even though the patient information on the questionnaires were anonymous, patients may not have trusted this to be the case, particularly if they were at the start of their care with the team and felt they may be accessing the service for some time. An alternative approach would have been to either approach patients with questionnaires directly or to ask patients directly if they would take part in interviews. However due to time constraints this was not possible.

Data analysis of the Care Aims questionnaires and interviews was completed using thematic networks as described by Attride-Stirling (2001). Due to the qualitative nature of the data and working in the same organisation as the teams in the case studies it is possible that this may have biased interpretation of data. Data analysis could have been strengthened by an independent researcher also undertaking the thematic analysis and seeing if similar thematic networks emerged.

## **9.8 Implications for Practice**

This study has several implications for practice at both an operational and strategic level for both integrated team working and implementation of Care Aims. These are discussed below.

### **9.8.1 Implications for Clinicians**

It is important that clinicians working in integrated teams understand that a range of interdependent factors can influence teamworking. Clinicians working in integrated team should reflect and explore with colleagues the impact of the different factors in the context of their own team. Exploring factors such as how the team views itself, its preferred approach to care and team vision may enable the team to better understand the potentially different perspectives within the team and support development of a shared view across the team. This would also facilitate understanding of the implications for how the team assess, plan and deliver care. The minimum dataset to support cross case analysis of integrated teamworking (table 9.1, p.229) may potentially provide a framework to facilitate this.

Teams should also explore how they engage and involve patients in their care to facilitate a more patient centred approach to care. Particular areas where this could be developed in practice may be in goal setting and care planning. Practitioners may benefit from further training in this area.

Where teams are considering implementing Care Aims practitioners should consider the range of factors that may influence implementation. Use of the framework identifying various factors that influence implementation of Care Aims (table 9.2, p.232) may facilitate greater understanding of their own and colleagues perceptions. This would also support understanding of how Care Aims may impact differently for different professions and may potentially require a greater level of change for some professions than others.

### **9.8.2 Implications for Leaders and Managers**

Leaders and managers should reflect on the level of integration in teams they manage and explore how fully integrated teams need to be. The use of the case study framework (table 9.1, p.229) may help managers explore this and also identify areas where teams require greater support and development. Whilst use of cultural and team climate assessment measures such as the OCAI and TCI are recommended, it is also recommended that they are not used in isolation. Use of other data sources (table 9.1, p.229) are strongly recommended to gain a more indepth and broader understanding of teams.

This study suggests further exploration as to whether teams need to be integrated to provide good patient care. Commissioners should explore the outcomes they are hoping to achieve from integrated team working and the level of integration required to deliver the outcomes for patients.

Leaders should explore themes regarding leadership and the potential implications for their own role particularly in engaging others in leadership and developing and sharing vision and impact on culture. Leaders should consider further exploration of different models of leadership such as collective leadership and how this may impact on team functioning.

Where leaders and managers are considering implementing Care Aims they should seek to explore and understand the current culture and context in teams prior to

implementation and the different culture Care Aims implementation may require. Use of a framework such as that described in table 9.2 (p.232) may help facilitate this. Managers should also consider exploring the impact of Care Aims implementation with commissioners to that there is shared understanding of potential impact prior to implementation.

Where teams are implementing Care Aims there should be open dialogue with commissioners to ensure that Care Aims and potential implications of implementation are understood.

### **9.9 Implications for Research**

This study has suggested a range of areas for future research for both integrated teamworking and implementation of Care Aims.

Use of the framework to facilitate cross case analysis of integrated team working and integrated care would support comparisons being made between case studies. A lack of empirical evidence is often cited as an area for future research and use of a minimum dataset would support development in this area.

Further case studies both in the organisation and with similar and different teams in other organisations would be areas for future research to explore if similar or different themes emerged.

Similar to previous research this study has struggled to engage patients and explore their views of integrated team working. This is a gap in the literature. It would also be interesting to explore whether patients feel care has to be provided in an integrated way to meet their needs.

As described in the literature search there is little published literature regarding Care Aims. Potential areas for future research could include:

- Testing of the framework for implementation with teams in the same and different organisations
- Exploring patient's views of Care Aims and impact on their care
- Exploring the use of Care Aims in teams with medical and/or social care staff

## **9.10 Implications for Policy**

This case study has reported and compared the findings of the culture and context for AHPs working in integrated teams. This study has highlighted the lack of detail in published case studies to enable comparison on a wider scale. Similar to many of the published studies this study reports findings predominantly from the perspective of staff. This study also starts to explore whether care has to be provided in an integrated way to best meet the needs of patients. An emerging theme throughout this study is the influence of culture and model of practice on integrated working and delivery of care.

Policy makers should consider the lack of empirical comparative data in the development of future policy regarding the provision of integrated care and integrated team working. Consideration should also be given to the understanding of culture and model of care for integrated working and delivery of care in undergraduate training in developing the future workforce.

## **9.11 Summary**

This chapter has identified the contribution this study makes to the evidence base, explored the limitations of this study and suggested implications for practice, research and policy.

The cross case analysis identified ten factors which influenced both integrated team working and implementation of Care Aims. Some factors appeared to have greater influence than others on integrated teamworking. As the teams were of a similar type there was limited evidence in relation to integration being targeted at certain cohorts of patients. There was stronger evidence to support the influence of team dynamics, leadership and approach to care. Movement away from a biomedical model appearing particularly significant.

Cross case analysis of published literature proved challenging. Comparative analysis of the case studies in this thesis has led to the development of a minimum dataset that would enable more detailed understanding of the evidence base and potentially support teams to understand better the context in which they are operating.

Similar to integrated teamworking, cross case analysis suggested that Care Aims implementation was influenced particularly by the dominant model of care present in a

team prior to implementation and how the introduction of Care Aims was managed. Also significant appeared the level of change required by individuals and teams, acknowledging that Care Aims may be more difficult for some professions and teams to implement than others. A framework to support implementation of Care Aims by identifying which factors may act as potential barriers and facilitators has also been developed.

This study adds to the literature for integrated team working by providing a detailed comparative analysis of several integrated teams within the same organisation. Unlike previous studies these case studies all explored the role of AHPs. This study also adds to the limited evidence base for Care Aims by exploring and comparing the implementation and use of Care Aims in several integrated teams.

## CHAPTER 10

### CONCLUSION

The initial aim of the first part of this study was to investigate the Care Aims approach and effect of culture and context on integrated team working for AHPs in primary care settings. This has included:

- identifying the drivers for selection of Care Aims by the organisation
- documenting the implementation of Care Aims through a range of prospective case studies using comparative and descriptive case analysis
- eliciting the reported perceptions of team members and patients in relation team type role and function
- analysing the relationship between implementation, culture and context.

The managers described a range of drivers for selecting and introducing Care Aims to the organisation. These appeared to create a positive context for change for Care Aims to be implemented. Comparative analysis of Care Aims implementation and use in several case studies identified that the level of success have varied greatly. Expected outcomes may have been influenced by the manager's different perspectives of Care Aims and the lack of a consistent vision for the outcomes use of Care Aims would achieve. Both professional and organisational culture also appears to have influenced managers need for change, understanding of Care Aims.

The case studies identified that within teams there were frequently a range of perceptions about team type although role and function appeared to show less differences. This may support existing evidence that terminology relating to team type is used inconsistently or reflect the different views in the teams.

It has not been possible to identify outcome and performance measures or their relationship with implementation, culture and context. This would benefit from further research.

The cross case analysis identified ten categories that appeared to influence integrated team working. Some of the categories identified were similar to themes identified in the literature exploring facilitators and barriers to integrated team working, such as leadership, staff roles and responsibilities, vision and professional culture. However different categories also emerged e.g. service type, team climate and relationship with

the patient. Surprisingly a positive team climate did not appear to relate to level of integration although the social desirability scores may have biased the results. The interdependency between the categories is also apparent, with philosophy and approach to care influencing all. Where there was a less dominant biomedical approach to care teams appeared to work in a more integrated way. The cross case analysis also appeared to suggest that AHPs were able to work in an integrated way with each other but less so with other professions and this too may be due a shared philosophical approach to care.

Similarly Care Aims implementation appeared to be influenced by similar factors. The approach to care pre-Care Aims and how the introduction of Care Aims was managed appearing most significant. The findings also appeared consistent with the evidence base for managing change.

This study also suggested parallels between extent of integrated team working and success of Care Aims implementation. The more integrated a team appeared to be, the more successful Care Aims implementation also was. Whether level of team integration or introduction of Care Aims was more significant factor is unclear.

The aim of the second part of this study was to evaluate and compare the Care Aims approach with other relevant models for integrated team working for AHPs in primary care settings.

One of the challenges of this study has been identifying sufficiently detailed case studies to enable comparative analysis. Additionally the evidence base for use of Care Aims in an integrated team is sparse. Therefore it was not possible to evaluate and compare Care Aims with other models of integrated teamworking. As a result of the comparative analysis in this thesis a framework for a minimum data set to enable cross case analysis of case studies exploring integrated team working is proposed. This will facilitate a better understanding of the evidence base.

This study has also led to the development of a framework to support implementation of Care Aims. The framework by identifying the potential barriers and facilitators to implementing Care Aims could support teams to identify those areas which may benefit from greater attention and support during implementation.

The importance of context for integrated team working and provision of integrated care is starting to be better understood. This study adds to the literature for integrated team

working by exploring and comparing several integrated teams within the same organisation. Unlike previous studies, these case studies explicitly explored the role and impact for AHPs of working in an integrated team.

This study also adds to the limited evidence base for Care Aims by exploring the implantation and use of Care Aims in integrated teams and also comparing the introduction and use of Care Aims in several teams in the same organisation.

**Key points:**

- Integrated team working is influenced by a range of interdependent factors, particularly philosophy and approach to care.
- Inconsistent use of terminology limits comparative analysis of the integrated team working evidence base. A framework and minimum dataset could support comparative analysis and is proposed.
- Barriers and facilitators to the implementation of Care Aims can be identified. Particularly significant are approach to care and management of change. Use of the proposed framework could help teams more successfully implement Care Aims.
- The more integrated a team appeared to be the more successful Care Aims implementation appeared.

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## **APPENDIX 1 – INTERVIEW SCHEDULE MANAGERS**

### **INTERVIEW SCHEDULE – TRUST MANAGEMENT TEAM**

Test of audio-recording to ensure working.

Record date, time, venue and who is present.

Thank you for agreeing to take part in this interview. Please can you confirm that you have read the information sheet and completed a consent form.

You may stop this interview at any time.

One of the aims of the research project is to understand why the organisation decided to implement the Care Aims approach.

1. Please tell me in a few words how you would describe the Care Aims approach
2. Please describe the sequence of events that led to the organisation thinking about implementing an approach like Care Aims?
3. Please describe the circumstances leading up to this incident?
4. When did the sequence of events happen?
5. How did you feel about it?
6. What were you thinking?
7. What was it about this incident that was a prompt for Care Aims being implemented?
8. What did you hope to see happen by introducing the Care Aims?

Additional probing questions may be asked to encourage participants to provide maximal information and detail regarding their experiences.

The research project is also exploring how Care Aims is being implemented in teams.

9. Can you describe an event/incident that demonstrated to you that Care Aims was being implemented in teams?
10. Please describe the circumstances leading up to this event/incident?
11. When did the incident happen?
12. What was positive/negative about the incident/experience?
13. How did you feel about it?
14. What were you thinking?

Thank you for taking part. You will be sent a summary of the study on completion.



University Of Central Lancashire  
Preston, Lancashire  
United Kingdom  
PR1 2HE

## The Care Aims Approach and Integrated Team Working

### INFORMATION LEAFLET FOR TEAM MEMBERS (STAFF) (V2)

We would like you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

#### **Why is the study being carried out?**

This study aims to find out some of the factors that support successful integrated team working for Allied Health Professions (e.g. physiotherapists, speech and language therapists, occupational therapists) in community settings and is looking at an approach called Care Aims that teams use. This study has four objectives:

1. To identify and understand why the Trust chose to use the Care Aims approach
2. To identify appropriate and relevant outcome and performance measures
3. To look at how the Care Aims approach was implemented in different teams
4. To explore the relationships between implementation of Care Aims, context, culture and outcomes for patients.

#### **Who is doing the research?**

The research is being done by Caroline Waterworth, as part of a PhD programme. Caroline is a service manager with the Trust managing services for \_\_\_\_\_. The research has been approved by an NHS ethics committee, the University of Central Lancashire and by \_\_\_\_\_ Trust.

### **Selecting participants**

You have been invited to take part because you are in a Trust team using the Care Aims approach and the team contains at least one Allied Health Professional (Occupational Therapist and/or Physiotherapist and/or a Speech and Language Therapist and/or Podiatrist).

### **What is involved in this study?**

We are asking staff to complete questionnaires – the first is about the implementation of the Care Aims approach in your team. At a later date you will be asked to complete 2 further questionnaires. Both questionnaires are anonymous but coded so that responses can be linked to each team.

The first questionnaire also asks if you would be willing to participate in a semi-structured interview which will ask about how the Care Aims approach was implemented in your team. Not everyone who expresses an interest may be chosen to take part in an interview.

### **Do I have to take part?**

No, it is up to you to decide and whether you choose to take part or not. Please take time to read the information. You can also speak to your Team manager or contact Caroline Waterworth via the University of Central Lancashire using the email address below. If you wish to participate in an interview please complete the form at the end of the questionnaire.

### **How much time will it take?**

The questionnaires take about 20 minutes each to complete. Please return it to Caroline Waterworth, Address\_\_\_\_\_. The semi-structured interview will take place at a mutually agreed time and venue and last up to a maximum of 1 hour.

### **When and where is the research taking place?**

The project is expected to start early in 2011 and data collection to take place during 2011.

The research is taking place in \_\_\_\_\_ NHS Trust.

### **What are the possible risks and benefits of taking part in this study?**

No risks have been identified. The study findings will help us to understand better how NHS staff can work better in teams to improve patient care. If you indicate on the

questionnaire that you are willing to take part in an interview and then decide not to, you can withdraw from the interview at any time.

**What can I do if I am not happy with the study?**

If for any reason you are not happy with any aspect of the study please ask to speak to one of the research team who will do their best to answer your questions.

Caroline Waterworth: email [CJWaterworth@uclan.ac.uk](mailto:CJWaterworth@uclan.ac.uk)

Dr Hazel Roddam: email [HRoddam@uclan.ac.uk](mailto:HRoddam@uclan.ac.uk) Tel: 01772 895484

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. Details can be found on the university website: [www.uclan.ac.uk](http://www.uclan.ac.uk) or by contacting:

Complaints Liaison Officer  
Student and Academic Support Service  
Foster Building  
University of Central Lancashire  
PRESTON  
PR1 2HE

e-mail: [complaintsliason@uclan.ac.uk](mailto:complaintsliason@uclan.ac.uk)



University Of Central Lancashire  
Preston,  
Lancashire  
United Kingdom  
PR1 2HE

**This study is exploring how the Care Aims approach was implemented in your team. It would be helpful to understand more about your team first.**

1. Please describe what your team does?

2. Please describe what type of team it is e.g. multi-disciplinary, integrated, interdisciplinary, multi-professional?

3. What is your role within the team?

**The next few questions are about how the Care Aims approach was implemented in your team.**

4. Please describe the Care Aims approach in your own words?

5. Please describe the sequence of events that took place and are taking place to implement Care Aims in your team?

6. Please describe an incident or event that happened that you found helpful when your team was implementing the Care Aims approach?

7. Why was it helpful?

8. Please describe an incident or event that happened that you found less helpful when your team was implementing the Care Aims approach?

9. Why was it less helpful?

**The next few questions are about using the Care Aims approach. If you have not used the Care Aims approach in your work please go to question 14.**

10. Please describe a time when you used the Care Aims approach?

11. How did you feel about it?

12. What were you thinking?

13. What was the outcome?

**The next few questions are about you.**

14. How long have you worked in this team?

|  |                          |                   |                          |
|--|--------------------------|-------------------|--------------------------|
| Less than 6 months                     | <input type="checkbox"/> | 6 months – 1year  | <input type="checkbox"/> |
| More than 1 year but less than 2 years | <input type="checkbox"/> | More than 2 years | <input type="checkbox"/> |

15. What band is your job within the team?

|                |                          |             |                          |                 |                          |
|----------------|--------------------------|-------------|--------------------------|-----------------|--------------------------|
| Band 2, 3 or 4 | <input type="checkbox"/> | Band 5 or 6 | <input type="checkbox"/> | Band 7 or above | <input type="checkbox"/> |
|----------------|--------------------------|-------------|--------------------------|-----------------|--------------------------|

16. How old are you? (please tick one box)

|                   |                          |                        |                          |
|-------------------|--------------------------|------------------------|--------------------------|
| 18 – 23 years old | <input type="checkbox"/> | 24 – 30 years old      | <input type="checkbox"/> |
| 31 – 40 years old | <input type="checkbox"/> | 41 – 50 years old      | <input type="checkbox"/> |
| 50 – 60 years old | <input type="checkbox"/> | More than 60 years old | <input type="checkbox"/> |

Thank you for completing this questionnaire. Please return the questionnaire using the internal post to:

Caroline Waterworth,  
Address

A summary of the results will be sent to teams taking part in this study.

If you are interested in taking part in an interview looking in more depth at implementation of the Care Aims approach, please complete the form on the next page and send the tear off slip to Caroline Waterworth in a separate envelope to your questionnaire response.

I am interested in taking part in an interview about how Care Aims is being implemented in my team.

Name:

---

Email:

---

Contact telephone number:

---

Base:

---

Please identify when it is most convenient to contact you:

---

---

Please indicate how you would prefer to be contacted (please tick all relevant boxes)

Face to face

Telephone

Email

Please return to Caroline Waterworth, Address \_\_\_\_\_

Thank you

## **APPENDIX 3 – INTERVIEW SCHEDULE TEAM MEMBERS**

### **INTERVIEW SCHEDULE –TEAM MEMBERS (STAFF)**

Test of audio-recording to ensure working.

Record date, time, venue and who is present.

Thank you for agreeing to take part in this interview. Please can you confirm that you have read the information sheet and completed a consent form?

You may stop this interview at any time.

Some of the questions are similar to those in the questionnaire. As the questionnaires were anonymous the information from your questionnaire is not included in the interview. Please answer questions as fully as possible and try not to refer to the response you gave in your questionnaire.

**This study is exploring how the Care Aims approach was implemented in your team. It would be helpful to understand more about your team first.**

1. Please describe what your team does?
2. Please describe what type of team it is e.g. multi-disciplinary, integrated, interdisciplinary, multi-professional?
3. What is your role within the team?
4. How long have you worked with the team?

**The next few questions are about how the Care Aims approach was implemented in your team.**

5. Please describe the Care Aims approach in your own words?
6. Please describe the sequence of events that took place to implement Care Aims in your team, focussing on anything that happened that you think was significant, whether it was good or bad?

Additional probing questions will be used to gain further insights. The participant may describe several incidents. Questions may include:

7. Why was it helpful?
8. Why was it less helpful?
9. How did you feel?
10. What did you think?

**The next few questions are about using the Care Aims approach.**

11. Please describe a time when you used the Care Aims approach?

12. How did you feel about it?

13. What were you thinking?

14. What was the outcome?

15. Have there been times when you have decided not to use the Care Aims approach?

16. Please describe a time when you did not use the Care Aims approach?

17. How did you feel about it?

18. What were you thinking?

19. What was the outcome?

Additional probing questions may be asked to encourage participants to provide maximal information and detail regarding their experiences.

Thank you for taking part. You will be sent a summary of the study on completion.

## APPENDIX 4 - PATIENT INFORMATION SHEET AND CARE AIMS QUESTIONNAIRE



University Of Central Lancashire  
Preston, Lancashire  
United Kingdom  
PR1 2HE

### The Care Aims Approach and Integrated Team Working

#### INFORMATION LEAFLET FOR PATIENTS (V2)

We would like you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

#### **Why is the study being carried out?**

This study aims to find out some of the factors that support successful integrated team working for Allied Health Professions (e.g. physiotherapists, speech and language therapists, occupational therapists) in non-hospital settings and is looking at the way care is provided using an approach called Care Aims.

#### **Who is doing the research?**

The research is being done by Caroline Waterworth, as part of a PhD programme. Caroline is a service manager with the Trust managing services for Children and Families. The research has been approved by an NHS ethics committee, the University of Central Lancashire and by \_\_\_\_\_ Trust.

#### **Selecting participants**

You have been invited to take part because you are a patient who is receiving treatment from a Trust team using the Care Aims approach and the team contains at least one Allied Health Professional (Occupational Therapist and/or Physiotherapist and/or a Speech and Language Therapist and/or Podiatrist).

**Please turn over to next page**

**What is involved in this study?**

We are asking patients to complete a questionnaire about their experience of the service. All questionnaires are anonymous but coded so that responses can be linked to each team. Patients are also being asked to indicate if they would be willing to take part in an interview with Caroline Waterworth at the end of the questionnaire.

**Do I have to take part?**

No, it is up to you to decide and whether you choose to take part or not, it will not affect your care now or in the future. Please take time to read the information. You can also speak to your NHS therapist/nurse or contact Caroline Waterworth via the University of Central Lancashire. If you decide to take part please complete the questionnaire. If you choose not to take part please ignore the questionnaire. If you are willing to take part in an interview please indicate this in the section at the end of the questionnaire.

**How much time will it take?**

The questionnaire takes about 20 minutes to complete. Please return it in the envelope provided when you next attend the PCT/Community Clinic. If you are willing to take part in an interview, you will be contacted directly by Caroline Waterworth to arrange the interview at a time and venue suitable for both. The interview will last up to a maximum of minutes. Not everyone who expresses an interest may be chosen to take part in an interview.

**When and where is the research taking place?**

The project is expected to start early in 2011 and for completion of questionnaires and interviews to take place during 2011. The research is taking place in the Trust.

**What are the possible risks and benefits of taking part in this study?**

No risks have been identified. The findings from the study will help us to understand better how NHS staff can work better in teams to improve patient care. The completion of the study will not affect any planned treatment sessions with your therapist/nurse.

**Will I receive “out of pocket” expenses?**

Unfortunately there is no funding to reimburse parking or travel for patients taking part in this study.

**Please turn over to next page**

**What will happen if I don't want to continue with the study?**

If you do not want to take part, please do not complete the questionnaire. Your decision to withdraw will not affect you, or the care you receive in any way now or in the future. If you indicate on the questionnaire that you are willing to take part in an interview and then decide not to, you can withdraw from the interview at any time. Again this will not affect you or the care you receive in any way.

**What can I do if I am not happy with the study?**

If for any reason you are not happy with any aspect of the study please ask to speak to one of the research team who will do their best to answer your questions.

Caroline Waterworth: email [CJWaterworth@uclan.ac.uk](mailto:CJWaterworth@uclan.ac.uk)

Dr Hazel Roddam: email [HRoddam@uclan.ac.uk](mailto:HRoddam@uclan.ac.uk) Tel: 01772 895484

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. Details can be found on the university website: [www.uclan.ac.uk](http://www.uclan.ac.uk) or by contacting:

Complaints Liaison Officer  
Student and Academic Support Service  
Foster Building  
University of Central Lancashire  
PRESTON  
PR1 2HE

e-mail: [complaintsliason@uclan.ac.uk](mailto:complaintsliason@uclan.ac.uk)

**If there are any questions you do not wish to answer please leave the answer box blank.**

**This study is exploring how the Care Aims approach was implemented by the healthcare staff treating you. It would be helpful to understand more about your team/healthcare staff who are treating you.**

1. Please describe what you know about the service that you are being treated by and what their role is?

2. Please describe what type of team it is e.g. made up of lots of different healthcare professionals, made up of one type of healthcare professional

3. Which members of the team (jobs not individual names) have you come into contact with e.g. nurse, physiotherapist?

**The next few questions ask about your experience of the service. Please think about your experience of being assessed and treated by the team.**

4. Please describe a situation or event in which you either observed or experienced something that impressed you as an example of effective care by the team/person treating you?

**Please turn over to next page**

5. Why was this particularly effective?

6. Please describe a situation or event that you found helpful during your treatment and/or assessment?

7. Why was this particularly helpful?

8. Please describe a situation or event that you found unhelpful?

9. Why was this unhelpful?

**Please turn over to next page**

10. Thinking about when you were assessed, please describe what you were hoping would happen as a result of the assessment.

11. Thinking about what you were hoping would happen as a result of the assessment and how you are now, how do you feel about your illness/condition?

Thank you for completing this questionnaire. Please return the questionnaire in a sealed envelope (attached) to the clinician treating you or to any Health Centre for posting in the internal post. The questionnaire will be sent to:

Caroline Waterworth,  
(Address)

If you are interested in taking part in an interview looking in more depth at your experience of the service, please complete the form on the next page and send in a sealed envelope (attached) to the clinician treating you or to any Health Centre for posting in the internal post for the attention of Caroline Waterworth. Please send in a separate envelope to your questionnaire.

**Please turn over to next page**

**I am interested in taking part in an interview about my experience of the service.**

Name:

---

Email:

---

Contact telephone number:

---

Please identify when it is most convenient to contact you:

---

---

Please indicate how you would prefer to be contacted (please tick all relevant boxes)

Telephone

Email

Please return this page to

Caroline Waterworth,

Address

Thank you

## **APPENDIX 5 – INTERVIEW SCHEDULE – PATIENTS**

Test of audio-recording to ensure working.

Record date, time, venue and who is present.

Thank you for agreeing to take part in this interview. Please can you confirm that you have read the information sheet and completed a consent form.

You may stop this interview at any time.

Some of the questions are similar to those in the questionnaire. As the questionnaires were anonymous the information from your questionnaire is not included in the interview. Please answer questions as fully as possible and try not to refer to the response you gave in your questionnaire.

**This study is exploring how the Care Aims approach is being implemented by the healthcare staff treating you. It would be helpful to understand more about your team/healthcare staff who are treating you.**

1. Please describe what you know about the purpose of the service you are being treated by?
2. Please describe what type of team it is e.g. made up of lots of different healthcare professionals, made up of one type of healthcare professional
3. Which members of the team (jobs not individual names) have you come into contact with e.g. nurse, physiotherapist?
4. How long have you been treated by this team?

**The next few questions ask about your experience of the service. Please think about your experience of being assessed and treated by the team.**

5. Thinking about the first time you were seen by the nurse/therapist, please describe what happened?
6. How did you feel?
7. What did you want to happen as a result of the assessment?
8. What did you find helpful?
9. What did you find unhelpful?
10. What happened next?

11. How did you feel about this?
12. How was it decided what would happen next?

**The next few questions are about the times you met with the therapist/nurse after your assessment.**

13. Please describe a situation or event in which you either observed or experienced something that impressed you as an example of effective care by the team/person treating you?
14. Why was this particularly effective?
15. Please describe a situation or event that you found helpful during your treatment and/or assessment?
16. Why was this particularly helpful?
17. Please describe a situation or event that you found unhelpful?
18. Why was this unhelpful?
19. At the beginning you described what you wanted to happen as a result of the assessment. Please a situation or event where you felt this had happened (or not)?
20. What happened?
21. How did you feel?
22. What happened next?
23. Thinking about the reason why you are seeing the nurse/therapist, please describe a situation or event where you felt there was a difference in how you managed your condition/illness?
24. What happened?
25. How did you feel?
26. What were the circumstances leading up to this?
27. What happened next?
28. How would you describe your experience overall?

Additional probing questions may be asked to encourage participants to provide maximal information and detail regarding their experiences.

Thank you for taking part. You will be sent a summary of the study on completion.

## APPENDIX 6 – TEAM INFORMATION SHEET AND CONSENT FORM FOR INTERVIEWS



University of Central Lancashire  
Preston, Lancashire  
United Kingdom  
PR1 2HE

### The Care Aims Approach and Integrated Team Working

#### INFORMATION LEAFLET FOR TEAM MEMBERS (V3)

We would like you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

#### **Why is the study being carried out?**

This study aims to find out some of the factors that support successful integrated team working for Allied Health Professions (e.g. physiotherapists, speech and language therapists, occupational therapists) in community settings and is looking at an approach called Care Aims that teams use. This study has four objectives:

1. To identify and understand why the Trust chose to use the Care Aims approach
2. To identify appropriate and relevant outcome and performance measures
3. To look at how the Care Aims approach was implemented in different teams
4. To explore the relationships between implementation of Care Aims, context, culture and outcomes for patients.

#### **Who is doing the research?**

The research is being done by Caroline Waterworth, as part of a PhD programme. Caroline is a service manager with the Trust managing services for \_\_\_\_\_. The research has been approved by an NHS ethics committee, the University of Central Lancashire and by \_\_\_\_\_-Primary Care Trust and \_\_\_\_\_ NHS Trust.

### **Selecting participants**

When you completed the questionnaire you indicated that you were willing to take part in an interview. You were invited to take part because you are in a Trust team using the Care Aims approach and the team contains at least one Allied Health Professional (Occupational Therapist and/or Physiotherapist and/or a Speech and Language Therapist and/or Podiatrist).

### **What is involved in this study?**

You have been invited to participate in a semi-structured interview which will ask about how the Care Aims approach is being implemented in your team.

### **Do I have to take part?**

No, it is up to you to decide and whether you choose to take part or not. Please take time to read the information sheet. You can also speak to your Team manager or contact Caroline Waterworth via the University of Central Lancashire using the email address below.

### **How much time will it take?**

The semi-structured interview will take place at a mutually agreed time and venue and last up to a maximum of 1 hour. The interview will be recorded but you can stop the recording at any time to delete or change the words.

### **When and where is the research taking place?**

The project is expected to start early in 2011 and data collection to take place during 2011.

The research is taking place in the Trust.

### **What are the possible risks and benefits of taking part in this study?**

No risks have been identified. The study findings will help us to understand better how NHS staff can work better in teams to improve patient care. If you indicate you wish to take part in an interview you can withdraw from the interview at any time.

### **What can I do if I am not happy with the study?**

If for any reason you are not happy with any aspect of the study please ask to speak to one of the research team who will do their best to answer your questions.

Caroline Waterworth: email [CJWaterworth@uclan.ac.uk](mailto:CJWaterworth@uclan.ac.uk)

Dr Hazel Roddam: email [HRoddam@uclan.ac.uk](mailto:HRoddam@uclan.ac.uk) Tel: 01772 895484

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. Details can be found on the university website: [www.uclan.ac.uk](http://www.uclan.ac.uk) or by contacting:

Complaints Liaison Officer  
Student and Academic Support Service  
Foster Building  
University of Central Lancashire  
PRESTON  
PR1 2HE

e-mail: [complaintsliason@uclan.ac.uk](mailto:complaintsliason@uclan.ac.uk)



University Of Central Lancashire  
Preston, Lancashire  
United Kingdom  
PR1 2HE

**The Care Aims Approach and Integrated Team Working**

**CONSENT FORM FOR TEAM MEMBERS (STAFF) (V3)**

**Title of Project:** Identifying the factors that support successful integrated team working for Allied Health Professionals in Primary Care Settings

**Researcher:** Caroline Waterworth

**Academic Supervisor:** Dr Hazel Roddam

**NRES No:** xxxxx

Please initial box

- 1. I confirm that I have read and understand the information leaflet for Team Members (staff) (V3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
- 3. I give consent to take part in the interview.
- 4. I give consent to be audio-recorded in the above-mentioned study.
- 5. I understand that the recording can be stopped at any time and words deleted or changed

6. I understand that all data gathered during the study will be stored in accordance with the Data Protection Act (1998) and retained for a period of 6 years in a secure place
7. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.
8. I understand that reports from this study will not contain any identifiable personal information. Direct quotes may be used, but will not be attributable to any participant.

|                                       |               |  |
|---------------------------------------|---------------|--|
| _____<br>Name of participant          | _____<br>Date | _____<br>Signature of participant          |
| _____<br>Name (person taking consent) | _____<br>Date | _____<br>Signature (person taking consent) |

When completed: 1 for participant and 1 for Researcher.

## APPENDIX 7 - PATIENT INFORMATION SHEET AND CONSENT TO INTERVIEW



University Of Central Lancashire  
Preston, Lancashire  
United Kingdom  
PR1 2HE

### **The Care Aims Approach and Integrated Team Working**

#### **INFORMATION LEAFLET FOR PATIENTS (V3)**

We would like you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

#### **Why is the study being carried out?**

This study aims to find out some of the factors that support successful integrated team working for Allied Health Professions (e.g. physiotherapists, speech and language therapists, occupational therapists) in non-hospital settings and is looking at the way care is provided using an approach called Care Aims.

#### **Who is doing the research?**

The research is being done by Caroline Waterworth, as part of a PhD programme. Caroline is a service manager with the Trust managing services for Children and Families. The research has been approved by an NHS ethics committee, the University of Central Lancashire and by \_\_\_\_\_ Trust.

#### **Selecting participants**

When you completed the questionnaire you indicated that you were willing to take part in an interview. You have been invited to take part because you are a patient who is receiving treatment from a Trust team using the Care Aims approach and the team contains at least one Allied Health Professional (Occupational Therapist and/or Physiotherapist and/or a Speech and Language Therapist and/or Podiatrist).

**What is involved in this study?**

You have been invited to participate in a semi-structured interview which will ask about how the care you received from Trust staff who are using the Care Aims approach. Consent is also being asked for to look at the health records the team who are treating you have for you. This is so that the interview can be cross-referenced with your casenotes to make the research more robust. The casenotes will only be looked at to check statements from your interview by the researcher and for no other purpose e.g. to look at how it was agreed what would happen after the assessment had taken place. The records will not be removed from NHS premises. The only notes made will be in relation to the interview and these will be anonymised.

**Do I have to take part?**

No, it is up to you to decide and whether you choose to take part or not, it will not affect your care now or in the future. Please take time to read the information. You can also speak to your NHS therapist/nurse or contact Caroline Waterworth via the University of Central Lancashire using the email address below.

**How much time will it take?**

The semi-structured interview will take place at a mutually agreed time and venue and last up to a maximum of 1 hour. The interview will be recorded but you can stop the recording at any time to delete or change the words.

**When and where is the research taking place?**

The project is expected to start early in 2011 and for completion of questionnaires and interviews take place during 2011. The research is taking place in the Trust.

**What are the possible risks and benefits of taking part in this study?**

No risks have been identified. The findings from the study will help us to understand better how NHS staff can work better in teams to improve patient care. The completion of the study will not affect any planned treatment sessions with your therapist/nurse now or in the future.

**Will I receive "out of pocket" expenses?**

Unfortunately there is no funding to reimburse parking or travel for patients taking part in this study.

**What will happen if I don't want to continue with the study?**

Your decision to withdraw will not affect you, or the care you receive in any way now or in the future. You can withdraw from the interview at any time. Again this will not affect you or the care you receive in any way.

**What can I do if I am not happy with the study?**

If for any reason you are not happy with any aspect of the study please ask to speak to one of the research team who will do their best to answer your questions.

Caroline Waterworth: email [CJWaterworth@uclan.ac.uk](mailto:CJWaterworth@uclan.ac.uk)

Dr Hazel Roddam: email [HRoddam@uclan.ac.uk](mailto:HRoddam@uclan.ac.uk) Tel: 01772 895484

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. Details can be found on the university website: [www.uclan.ac.uk](http://www.uclan.ac.uk) or by contacting:

Complaints Liaison Officer  
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e-mail: [complaintsliason@uclan.ac.uk](mailto:complaintsliason@uclan.ac.uk)



University Of Central Lancashire  
Preston, Lancashire  
United Kingdom  
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**The Care Aims Approach and Integrated Team Working**

**CONSENT FORM FOR PATIENTS (V3)**

**Title of Project:** Identifying the factors that support successful integrated team working for Allied Health Professionals in Primary Care Setting

**Researcher:** Caroline Waterworth

**Academic Supervisor:** Dr Hazel Roddam

**NRES No:** xxxx

Please initial box

- 1. I confirm that I have read and understand the information leaflet (V3) for Patients for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
  
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my healthcare or legal rights being affected.
  
- 3. I give consent to take part in the interview.
  
- 4. I give consent to be audio-recorded in the above-mentioned study.

- 5. I give consent for my health records the team who are treating me hold to be looked at to cross reference with the interview
  
- 6. I understand that the recording can be stopped at any time and words deleted or changed
  
- 7. I understand that all data gathered during the study will be stored in accordance with the Data Protection Act (1998) and retained for a period of 6 years in a secure place
  
- 8. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.
  
- 9. I understand that reports from this study will not contain any identifiable personal information. Direct quotes may be used, but will not be attributable to any participant.

|                              |      |                                   |
|------------------------------|------|-----------------------------------|
| Name of participant          | Date | Signature of participant          |
| Name (person taking consent) | Date | Signature (person taking consent) |

When completed: 1 for participant and 1 for Researcher.

## **APPENDIX 8 - ORGANISATIONAL CULTURE ASSESSMENT TOOL**

### **Organizational Culture Assessment Instrument**

Instructions for completing the Organizational Culture Assessment Instrument (OCAI).

The purpose of the OCAI is to assess six key dimensions of organizational culture. In completing the instrument, you will be providing a picture of how your organization (team) operates and the values that characterize it. No right or wrong answers exist for these questions, just as there is no right or wrong culture. Every organization will most likely produce a different set of responses. Therefore, be as accurate as you can in responding to the questions so that your resulting cultural diagnosis will be as precise as possible.

You are asked to rate your organization in the questions. This is your team. To determine which organization (team) to rate, you will want to consider the organization (team) that is managed by your boss (team leader), the strategic business unit to which you belong, or the organizational unit in which you are a member that has clearly identifiable boundaries i.e. your team.

The OCAI consists of six questions. Each question has four alternatives. Divide 100 points among these four alternatives depending on the extent to which each alternative is similar to your own organization (team). Give a higher number of points to the alternative that is most similar to your organization (team). For example, in question one, if you think alternative A is very similar to your organization (team), alternative B and C are somewhat similar, and alternative D is hardly similar at all, you might give 55 points to A, 20 points to B and C, and five points to D. Just be sure your total equals 100 points for each question.

Note, that the first pass through the six questions is labelled "Now". This refers to the culture, as it exists today. After you complete the "Now", you will find the questions repeated under a heading of "Preferred". Your answers to these questions should be based on how you would like the organization (team) to look five years from now.

## The Organizational Culture Assessment Instrument

| <b>1. Dominant Characteristics</b>  |  | <b>Now</b> | <b>Preferred</b> |
|-------------------------------------|--|------------|------------------|
| A                                   | The organization is a very personal place. It is like an extended family. People seem to share a lot of themselves.                              |            |                  |
| B                                   | The organization is a very dynamic entrepreneurial place. People are willing to stick their necks out and take risks.                            |            |                  |
| C                                   | The organization is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.   |            |                  |
| D                                   | The organization is a very controlled and structured place. Formal procedures generally govern what people do.                                   |            |                  |
|                                     | <b>Total</b>   |            |                  |
| <b>2. Organizational Leadership</b> |  | <b>Now</b> | <b>Preferred</b> |
| A                                   | The leadership in the organization is generally considered to exemplify mentoring, facilitating, or nurturing.                                   |            |                  |
| B                                   | The leadership in the organization is generally considered to exemplify entrepreneurship, innovating, or risk taking.                            |            |                  |
| C                                   | The leadership in the organization is generally considered to exemplify a no-nonsense, aggressive, results-oriented focus.                       |            |                  |
| D                                   | The leadership in the organization is generally considered to exemplify coordinating, organizing, or smooth-running efficiency.                  |            |                  |
|                                     | <b>Total</b>   |            |                  |
| <b>3. Management of Employees</b>   |  | <b>Now</b> | <b>Preferred</b> |
| A                                   | The management style in the organization is characterized by teamwork, consensus, and participation.   |            |                  |
| B                                   | The management style in the organization is characterized by individual risk-taking, innovation, freedom, and uniqueness.                        |            |                  |
| C                                   | The management style in the organization is characterized by hard-driving competitiveness, high demands, and achievement.                        |            |                  |
| D                                   | The management style in the organization is characterized by security of employment, conformity, predictability, and stability in relationships. |            |                  |
|                                     | <b>Total</b>   |            |                  |

| <b>4. Organization Glue</b>   |   | <b>Now</b> | <b>Preferred</b> |
|-------------------------------|---|------------|------------------|
| A                             | The glue that holds the organization together is loyalty and mutual trust. Commitment to this organization runs high.                               |            |                  |
| B                             | The glue that holds the organization together is commitment to innovation and development. There is an emphasis on being on the cutting edge.       |            |                  |
| C                             | The glue that holds the organization together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes. |            |                  |
| D                             | The glue that holds the organization together is formal rules and policies. Maintaining a smooth-running organization is important.                 |            |                  |
|                               | <b>Total</b>  |            |                  |
| <b>5. Strategic Emphases</b>  |   | <b>Now</b> | <b>Preferred</b> |
| A                             | The organization emphasizes human development. High trust, openness, and participation persist.   |            |                  |
| B                             | The organization emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.    |            |                  |
| C                             | The organization emphasizes competitive actions and achievement. Hitting stretch targets and winning in the marketplace are dominant.               |            |                  |
| D                             | The organization emphasizes permanence and stability. Efficiency, control and smooth operations are important.                                      |            |                  |
|                               | <b>Total</b>  |            |                  |
| <b>6. Criteria of Success</b> |   | <b>Now</b> | <b>Preferred</b> |
| A                             | The organization defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.         |            |                  |
| B                             | The organization defines success on the basis of having the most unique or newest products. It is a product leader and innovator.                   |            |                  |
| C                             | The organization defines success on the basis of winning in the marketplace and outpacing the competition. Competitive market leadership is key.    |            |                  |
| D                             | The organization defines success on the basis of efficiency. Dependable delivery, smooth scheduling and low-cost production are critical.           |            |                  |
|                               | <b>Total</b>  |            |                  |

## APPENDIX 9 – MANAGER’S INFORMATION SHEET AND CONSENT TO INTERVIEW FORM



University Of Central Lancashire  
Preston, Lancashire  
United Kingdom  
PR1 2HE

### The Care Aims Approach and Integrated Team Working

#### CONSENT FORM FOR MANAGERS (V2)

**Title of Project:** Identifying the factors that support successful integrated team working for Allied Health Professionals in Primary Care Setting

**Researcher:** Caroline Waterworth

**Academic Supervisor:** Dr Hazel Roddam

**NRES No:** xxxx

Please initial box

1. I confirm that I have read and understand the information leaflet (V2) for Managers for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I give consent to take part in the interview.
4. I give consent to be audio-recorded in the above-mentioned study.
5. I understand that the recording can be stopped at any time and words deleted or changed

6. I understand that all data gathered during the study will be stored in accordance with the Data Protection Act (1998) and retained for a period of 6 years in a secure place

7. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.

8. I understand that reports from this study will not contain any identifiable personal information. Direct quotes may be used, but will not be attributable to any participant.

|                              |       |                                   |
|------------------------------|-------|-----------------------------------|
| _____                        | _____ | _____                             |
| Name of participant          | Date  | Signature of participant          |
| _____                        | _____ | _____                             |
| Name (person taking consent) | Date  | Signature (person taking consent) |

When completed: 1 for participant and 1 for Researcher.

# APPENDIX 10 - POSTER PRESENTATION



## Care Aims and the effect of culture and context for integrated team working for Allied Health Professionals in Primary Care settings.

Caroline Waterworth, PhD student, University of Central Lancashire  
 Steve Willcocks, Principal Lecturer, Lancashire Business School, University of Central Lancashire  
 James Selfe, Professor of Physiotherapy, University of Central Lancashire  
 Hazel Roddam, Principal Lecturer, Allied Health Professions Research Unit, University of Central Lancashire

### Why did we undertake this study?

Care Aims is increasingly being used as a model of care within NHS teams, particularly by Allied Health Professionals (AHPs). This poster reports the findings of implementing Care Aims in three integrated community health teams, all containing physiotherapists. It comparatively analyses the impact of professional and team culture and climate on implementing a managed change. These findings are part of a wider study exploring the effect of culture and context on integrated team working for AHPs in primary care settings.

### Objectives

- To document the implementation of the Care Aims approach through a range of prospective case studies using comparative and descriptive case analysis
- To analyse the relationships between implementation, context, culture and outcomes

### Results

Data was analysed using the process described by Attride-Stirling to develop thematic networks.

#### Case Study 1 Global theme: Change management

|  |   |
|--|---|
| Recognition that current ways of working not effective or best for patients and want to change | <ul style="list-style-type: none"> <li>Professionals do not always make decisions for benefit of patients</li> <li>Previous practices not in patient's best interests</li> <li>Historically paternalistic attitudes towards patients</li> <li>Team climate generally positive but frustrations with current volume of work</li> </ul> |
| Team wants to implement Care Aims properly but are still learning and are anxious              | <ul style="list-style-type: none"> <li>Staff feel care aims not used properly in some teams</li> <li>Team have anxieties about implementing Care Aims</li> <li>Team want current state to change - Care Aims seen as the solution</li> </ul>  |

#### Case Study 2 Global theme: Change process is as important as the change

|  |  |
|--|--|
| Care Aims is about tasks and processes           | <ul style="list-style-type: none"> <li>Care Aims is about tasks</li> <li>We can choose which bits we implement</li> <li>Care Aims is about paperwork</li> </ul>  |
| Care Aims is not seen as a better way of working | <ul style="list-style-type: none"> <li>Care Aims is not effective</li> <li>Care Aims is subjective</li> <li>Lack of strong leadership and clear vision</li> <li>Care Aims is difficult</li> <li>Care Aims is no better than how we currently work</li> </ul> |
| Training is important                            | <ul style="list-style-type: none"> <li>Training varied</li> <li>Relationship between training and level of engagement</li> </ul>   |

**References:**  
 Attride-Stirling J. (2001) Thematic networks: an analytic tool for qualitative research. *Qualitative Research* Vol. 1, No. 3 pp 385-405  
 Fuda P. (2009) Why change efforts fail [online] Available from: <http://www.peterfuda.com/wp-content/themes/peterfuda-bootstrap/content/Why-Change-Efforts-Fail.pdf> [Accessed 14 June 2015]  
**Ethics ref:**  
 NRES: 11/NW/0082 UCLAN: CA number 188

### Method

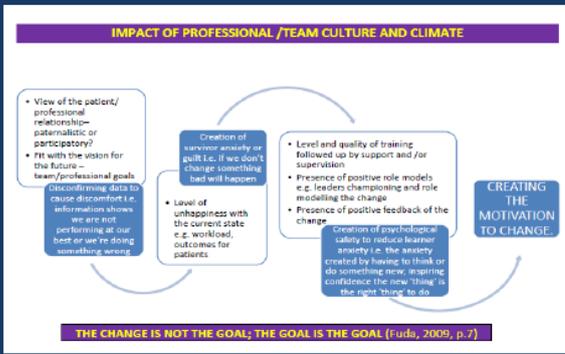
This qualitative study comprises of three case studies. The teams selected for the study could not be randomly selected as there were a limited number of teams in the organisation who met the inclusion criteria. All the teams in the study are community based, provide a range of specialist services and range from 7-20 people approximately. Team members were asked to complete a questionnaire based on the Critical Incident Technique and asked about their understanding, implementation and use of Care Aims. Team members could also opt in to a semi-structured interview also based on the Critical Incident Technique asking similar questions. Team members were also asked to complete two standardised assessment tools—the Organisational Culture Assessment Instrument (OCAI) and the Team Climate Inventory (TCI) to facilitate contextual comparison of culture and climate in each case study.

#### Case Study 3 Global theme: Change process

|                                   |  |
|-----------------------------------|--|
| Training is important             | <ul style="list-style-type: none"> <li>Training motivates implementation</li> <li>Understanding varies</li> <li>New people to the team do not have the same opportunities</li> </ul>   |
| Managed implementation            | <ul style="list-style-type: none"> <li>Implementation was planned and facilitated by the team</li> <li>Adapting the paperwork</li> </ul>   |
| Using Care Aims was natural       | <ul style="list-style-type: none"> <li>Implementation required little change</li> <li>Care Aims has been adapted for use</li> </ul>  |
| Conflicting priorities            | <ul style="list-style-type: none"> <li>Inconsistent prioritisation of patients</li> <li>Capacity and demand influence Care Aims use</li> <li>Conflict between Care Aims and Commissioning priorities</li> <li>Care Aims exposes gaps in commissioned services</li> </ul> |
| Challenging professional cultures | <ul style="list-style-type: none"> <li>Exposed differences between professional cultures</li> <li>Altered perception of own profession</li> <li>Training was challenging</li> <li>Impact focussed functional goal setting can be challenging</li> </ul>                  |

### Conclusion and Key findings

Change management was a common global theme in each case study, particularly the impact of team and professional culture on implementing managed change in the context of implementing Care Aims. In each case study successful Care Aims implementation appeared to correlate with the ability to be able to create the motivation to change.



RESEARCH

# Implementing Care Aims in an integrated team

Caroline Waterworth, Steve Willcocks, James Selfe, Hazel Roddam

## ABSTRACT

Care Aims is increasingly being used as a model of care within NHS services, particularly by allied health professionals. This article reports the findings of a pilot study exploring the impact of implementing Care Aims in an integrated community health team. It describes the main findings, and discusses the factors that appeared to impact on the implementation and use of the Care Aims approach in these teams. The model has been traditionally used in uni-professional teams rather than integrated teams. This case study suggests Care Aims has potential to support integrated team working. In this study, clinicians perceived Care Aims was a model that could improve care for patients, support professionals working together and support self-management. However, it is unclear whether it was Care Aims itself or the training and discussion that took place that enabled this team to develop and agree more consistent working practices. Similar to previous studies, this study has shown how team and professional culture can influence how team members work together and provide care in an integrated way. Team and professional cultures are also shown to influence how team members approach and embrace that change. As such, Care Aims may be more challenging to some staff groups to implement.

**Key Words:** Integrated team work • allied health professionals • care aims • culture

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Integrated care continues to be a priority, particularly for older people with multiple morbidities. Key messages in a recent report by Goodwin et al (2014) included that the starting point should be a clinical service model designed to improve care for people; professionals needing to work together in multidisciplinary teams (with clearly defined roles) and that success is more likely if there is a specific focus on working with individuals and informal carers to support self-management.

Care Aims is increasingly being used as a model of care within NHS services, particularly by allied health professionals. Care Aims is a model of practice developed by Kate Malcomson (2005a), which is designed to support clinicians to demonstrate evidence-based practice through

systematic reflection. Care Aims focuses on the impact and outcomes of care, and requires clinicians to identify their main reason for intervening.

This study offers a new approach to studying Care Aims in the context of integrated care, as opposed to previous work which has been undertaken in uni-professional services such as speech and language therapy and learning disabilities.

The authors wanted to understand the impact of Care Aims on integrated team working and explore whether Care Aims had the potential to facilitate integrated team working as there appeared to be parallels between Care Aims and some of the key messages supporting integrated team working and care.

This article reports the results of a pilot case study that is part of a wider research project exploring the effect of culture and context on integrated team working for allied health professionals (AHPs) working in primary care settings. There are many definitions of integrated team working (Maslin-Prothero and Bennion, 2010). For the purpose of this study, it is defined as a group of practitioners from different professions working together on a day-to-day basis, led by one person and usually based together.

### Literature review

AHPs are acknowledged as being essential to effective integrated care delivery, particularly in the care of older people (Scottish Government, 2012), yet similar to Donnelly et al (2013) the literature review found few published studies about integrated team working featuring allied health professionals.

It is acknowledged in the literature that there are various approaches to integration and that no one model is universally applicable (Curry and Ham, 2010) but that multiple factors contribute to its success. The facilitators and barriers to integrated care and integrated team working being well-documented (Cameron and Lart, 2003; Hudson, 2006a; 2006b; Morrow et al, 2005; Syson and Bond, 2010; Tucker, 2010; Cameron et al, 2012) with many of these appearing to reflect different dimensions of culture. Kodner (2002) described integration as a culture rather than structure:

*‘The glue that bonds the entity together, thus enabling it to achieve common goals and optimal results.’*

Care Aims is described as a ‘philosophy that has proven to be extremely versatile and can be adapted to any practice context, team structure or professional group, a standardised way of capturing and communicating clinical reasoning’ in addition to focusing on outcomes for clients (Malcomess, 2005). This suggests it has the potential to facilitate the cultural identity described by Petch (2014), which ‘transcends the traits of particular professions or individuals and

provides the most effective basis for the delivery of integrated provision and the achievement of organisational and individual outcomes’.

The literature review found few published studies about Care Aims and none could be found in relation to Care Aims and integrated team working. Those found related to uni-professional team working predominantly in the allied health professions (McCarthy et al 2001; Mowles et al, 2010; Stansfield, 2011; Miller et al, 2013).

### Method

The team in this qualitative pilot study covers two urban geographical localities in the north of England. They provide assessment, intervention and advice in relation to a specialist area of community healthcare within the NHS. While the overall team met the inclusion criteria for the study (Figure 1) as the team included members from nursing, occupational therapy and physiotherapy professions, one locality consisted of nurses only. However, the team was in the process of moving to one centralised base. The team members were introduced to Care Aims approximately one year prior to the start of this study. All members of the team were female. The team receives approximately 50 referrals per month with patients seen in their own home, residential/nursing homes and NHS outpatient clinics.

A questionnaire was distributed to seven members of the team. Consent to participate was implied by return of the questionnaire.

Figure 1. Team inclusion criteria

- The majority of team members have completed the full Care Aims training
- The team includes allied health professions
- The team is not undergoing any other major service change (e.g. merging with another team)
- The team manager is supportive of the research project and able to provide access to team members, team members’ time to fully participate in the study and willing for their team’s patients to be approached
- The team is not directly or indirectly managed by the researcher

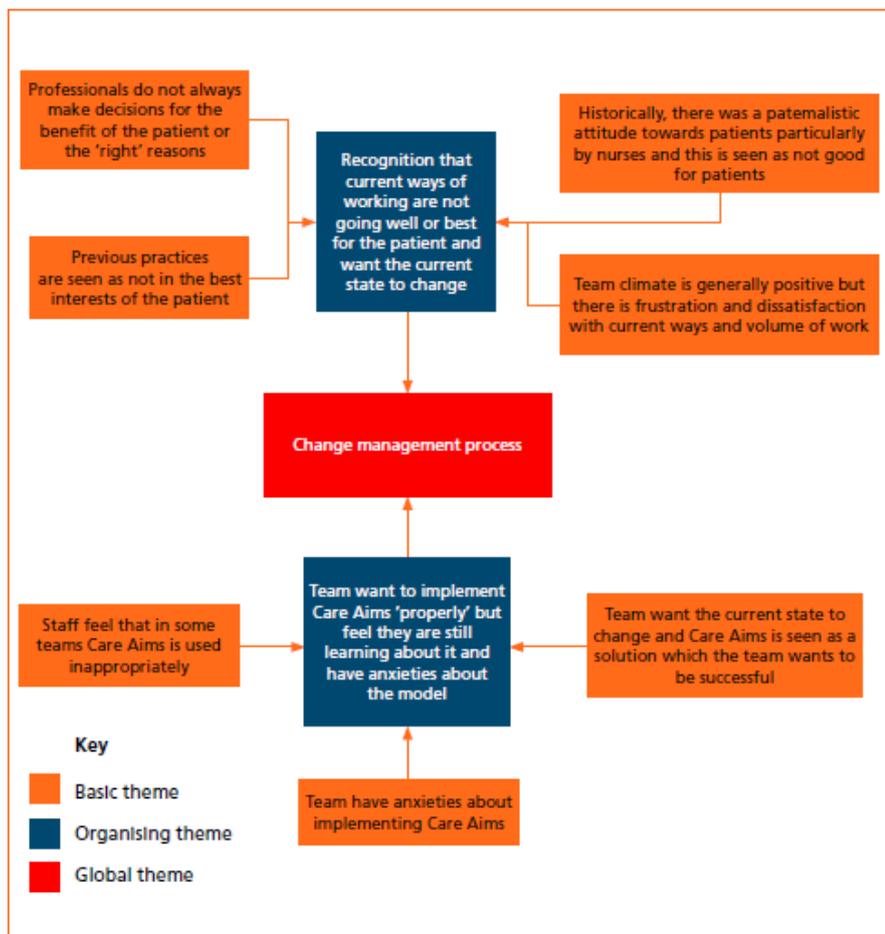


Figure 3. Change management process

respects, very different to how they had practiced and thought about the decisions they made previously.

*'The first thing with care aims is getting your head around it [...] especially for people like me who trained and worked for the NHS for years. And the way I trained was very much focused on what she could do for the patient [...] that that was difficult to some of us'.*

Despite all this, Care Aims was seen as a solution and the team wanted it to work.

## Theme 2: Professional cultures

The team recognised that professions have different cultures and values, and implied that Care Aims training facilitated their thinking about this. One AHP said:

*'Certainly myself and the physios see things slightly differently I think*



Figure 2. Global themes

The questionnaire also asked respondents if they would participate in a semi-structured interview in addition to completing the questionnaire.

The questionnaire asked respondents to give an account of their understanding, implementation and use of Care Aims. Questionnaire design was based on the critical incident technique (CIT) (Flanagan, 1954). CIT is recognised as a method of analysing culture (Mannion et al, 2008), advocated as a method for studying inter-professional work (Rawson, 1994), and had been employed in studies within healthcare settings (Bendtsen et al, 1999). It is considered a culturally neutral method (Gremler, 2004), is context-rich, and tries to provide a broader understanding of culture within the context it is applied (Jung et al, 2009).

The questions asked respondents to frame their responses in relation to a specific incident or experience which was chosen by the respondent. They were asked to focus on anything that they believed was significant in a positive or negative way. The interview schedule of questions took a similar approach with supplementary questions asked as appropriate.

The dataset was analysed using the process described by Attride-Stirling (2001) to develop thematic networks. As well as enabling a systematic and consistent approach to data analysis, this approach will facilitate cross case study comparison in the wider study.

Ethical and organisational research approval was gained from the NHS via the Integrated Research Application System (IRAS), University

of Central Lancashire and the organisation involved in this study.

## Results

Five team members (71%) responded to the questionnaires and two of the team also participated in semi-structured interviews. Questionnaire responses were representative of the professions and grades of staff within the team. A nurse and AHP took part in the interviews.

From the data, codes were further dissected into coded text segments. 120 coded text segments were identified and these were then grouped and interpreted as basic themes. The 20 basic themes were then clustered and six organising themes identified. The six organising themes were then summarised as global themes (Figure 2).

### Theme 1: change management process

The change management process appeared to be as important as the change itself. The team expressed their dissatisfaction with their current ways of working and volume of work, and a desire for the current state to change. There was a recognition that the traditional paternalistic attitude they held towards patients was not in the best interests of patient and at times decisions by professionals had been made not for the benefit of patients. For example, members of the team said:

*'There'll inevitably be one or two cases stick in your mind that you got wrong and you think hell, you know the guilt, clinician's guilt floods in.'*

*'It's a dangerous way to practice and I hadn't appreciated that.'*

The team wanted to maintain fidelity to Care Aims, but felt they were still learning and had anxieties about the model—particularly expressing concerns about patients either falling between services or the staff member missing something. The team described how they felt the training was critical, as Care Aims was in some

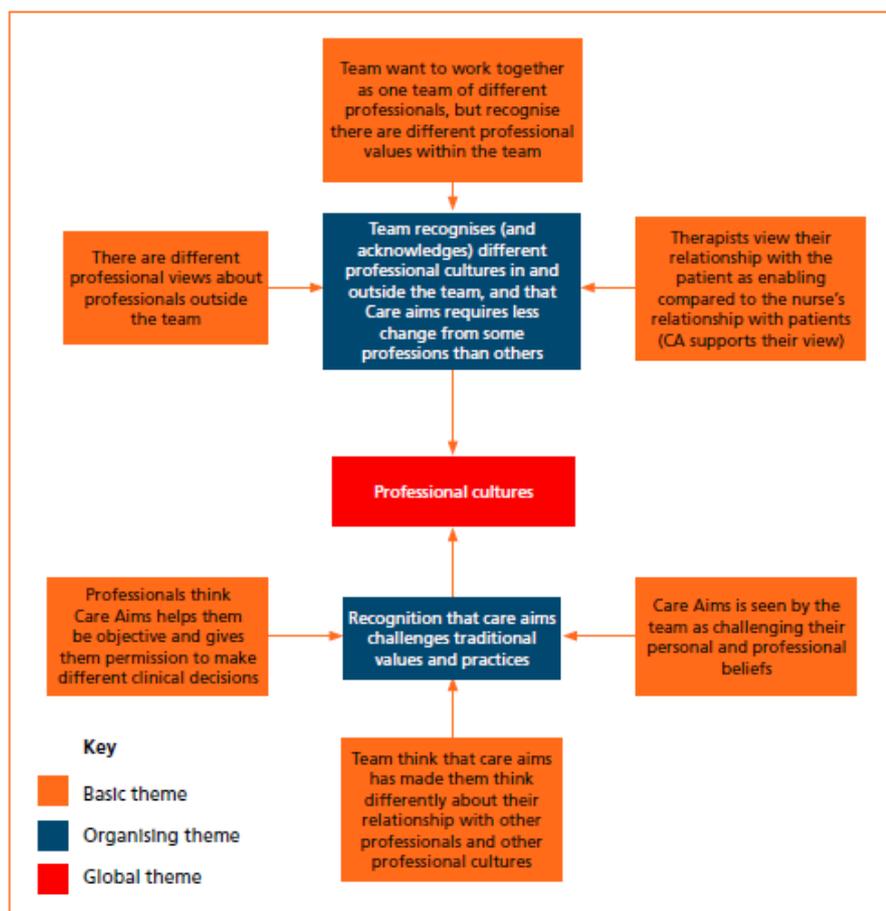


Figure 4. Professional cultures

*than a nursing model [...] and it is no disrespect to nurses. Nurses are very caring—looking after [people]—whereas therapists are enablers, and I think sometimes there's a clash with it.'*

Team members described the team differently with the AHP response describing the team as multiprofessional, and the other responses describing the team as multidisciplinary. When asked to describe their role in the team, the AHP identified that they provided specialist assessments relating to their profession, while

the other respondents were more general in their response and did not refer to their profession in relation to the assessment and treatment they provided.

The role of the patient was also described differently. The AHP felt 'equally the person has got to participate' whereas the nurse identified that 'I've now come to terms with things now that we can allow patients to make decisions'.

Questionnaire responses from the nurses in the team included having a 'misplaced sense of responsibility for patients', expressing surprise that patients can 'take responsibility for their

own healthcare—we can trust them’.

All the nursing respondents expressed fears that patients could fall between services because of referral criteria which may have contributed to their reluctance to fully adopt the care aims philosophy and assume a more task-based approach.

Professional culture appeared to impact on the extent to which individuals were able to support and promote self-management and the level of change required. Responses included ‘the difference sometimes we’re as therapists we’re looking at more, getting them to participate in active programs or they might look at a change’ with nurses describing their role as ‘a lot of the time we did just do to patients, who particularly accepted things’.

However, all the responses gave examples in relation to the respondents own profession with no examples demonstrating an integrated approach to care assessment or planning, which may be due to the impact of professional culture.

AHP responses tended to be more specific about their specialist role compared to the nurses possibly suggesting the AHP has a much stronger professional identity. Given the small number of AHP responses, this may be due more to the characteristics of the individuals than professional identity.

The team acknowledged the different professional views in the team, but see the value this can bring to the service they provide:

***‘There’s a lot of cross fertilisation of ideas and it does stop and make you think and think about things differently [...] and the patient will gain from that.’***

Care Aims appears to have made the team think about their relationship with other professionals and how other professions consider their duty of care. There appears to be recognition that they will approach things differently, but Care Aims seems to have given team members a confidence to challenge when they feel they are either receiving inappropriate referrals or working outside their team’s scope or duty of care, and to consider their relationships with other professionals differently.

### **Theme 3: Enablement for integrated working**

Care Aims appeared to be seen as an enabler for how the team wanted to work—particularly with other professionals and patients—but the team recognises that cultural change is required and this needs to be supported by the organisation.

The team describe themselves as a specialist service, but expressed they did not feel valued or respected by those who refer into their service. At the same time, they saw the value and wanted to work with other professionals.

***‘You are doing the patient a disservice if you don’t allow other people to become involved.’***

Team members viewed the team type, their roles and approach to care differently. Respondents used the terms multiprofessional and multidisciplinary to describe their team.

The team felt that one of the biggest impacts of the Care Aims training was in helping to clarify their role and responsibilities:

***‘For me the biggest impact was understanding where my role ends, so it’s not keeping patients on for endless reviews.’***

Team members identified that to embed Care Aims, they needed to change how they worked. Team members described how they felt liberated and had been given permission to act differently, implying that the organisation had given permission to act differently by commissioning Care Aims.

***‘Suddenly, I think it becomes quite liberating for a lot of staff because it can be really tough working with patients where there is no improvement but you feel you’ve reached an impasse you don’t have the confidence, the clinical confidence to let go.’***

Confidence regarding decision-making was frequently cited. This may have also come from discussion with other services.

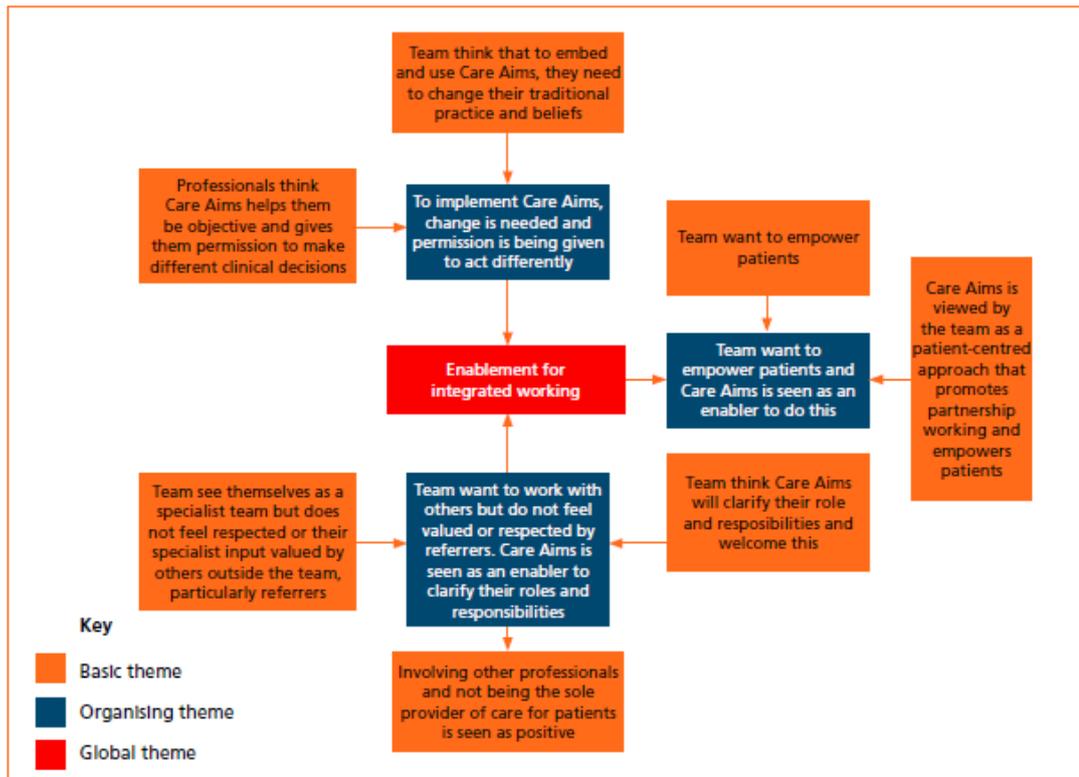


Figure 5. Enabling for integrated working

*‘Other services that are much further down the line than we are, most of them have said its been beneficial and it does change your practice’*

The team describe how they wanted to work in the future and described a different relationship with patients, namely with patients as equal partners in their care.

Respondents described the Care Aims as supporting them to work collaboratively with patients: ‘what impact can we help service users manage’; ‘looking at the impact of the problem and setting achievable goals and outcomes’ to those who choose a different option to that proposed ‘this was the patient’s choice and I had more professional confidence in accepting this’.

One of the difficulties several members of the team described was the challenge referrers found, changing from focusing on the problems the patient had, to the impact of those problems for the patient, so that the team could assess the clinical risk for the patient.

### Discussion

The thematic networks are discussed in the context of the key messages from Goodwin et al (2014).

#### A clinical/service model designed to improve care for people

The team appear to view Care Aims as an approach that will improve care for people. Similar to the findings of Goodwin et al (2014),

the team described how Care Aims had helped them clarify eligibility criteria for receiving care, a single point of referral, a single and holistic care assessment, a care plan and support from a multi-disciplinary team of professionals. While not explicit, it was implied by the team that one member of the team co-ordinated the care provided by the team for a patient.

The shift from problem-solving to impact focused thinking, which is integral to the care aims approach, appeared to lead to different discussions with patients and referrers about possible solutions with potentially longer term benefits for the patient. Unlike a medical model of care, Care Aims is designed to focus on outcome and requires the clinician to understand the meaning of a problem/diagnosis and its impact on the patient to identify interventions (Malcomess, 2005b)—i.e. the focus is on the reason for intervening as opposed to what is being done.

Care Aims training appears to have encouraged discussion in the team about different approaches to care and to provide the opportunity for the team to develop and agree more consistent working practices. These findings suggest similarities to the case study by Sylvain and Lamothe (2012) where the shared understandings facilitate the team to make sense collectively of events (implementing Care Aims) based on their experience. This has the potential to influence the development of integrated practice going forward, that is ingrained in the worked activities of the team.

It is widely acknowledged that cultural change occurs over time and this team are relatively new to using Care Aims and may need more time to consolidate its concepts.

#### Working together and role clarity

The literature frequently identifies clarity about roles, team objectives; culture and professional identity and tight role boundaries as factors that affect effective team working (Cameron and Lart, 2003; Robinson and Cottrell, 2005, Syson and Bond, 2010). Implementing the Care Aims approach appears to have caused the team to think about their own professional culture and those they work with—both in and outside their

team. Rather than seeing this as divisive, the team appear to acknowledge this and use their Care Aims training to reflect on how duty of care and team role may be seen by others, and how they can better describe their role and the value they bring to others.

Beales et al (2011) suggest that integrated teams need enough collaborative experience to develop a team culture so that the team culture is the predominant culture during times of change and/or conflict, rather than their professional culture. In this case study, the majority of members of the team have been part of this team for more than two years, some for up to 10 years, and articulated different views of team type and role. As the numbers are small in this pilot study, the results may be due to the characteristics of individuals, rather than professional identity, although Holmesland et al (2010) comment that professional identity is always dependent on personal identity.

However, Scott et al (2003) note that one characteristic of the NHS is the 'robustness of each occupational culture' and that the orientation of staff is professional more than corporate. Bloor and Dawson (1994) go further, commenting:

*'Of all the allied health professions (physiotherapists and occupational therapists), this group are the most concerned with the image of their profession' (Bloor and Dawson, 1994: 285).*

Therefore, their professional identity may be stronger in comparison to their team/organisational identity.

#### Supporting self-management

Care Aims asks the clinician to consider the clinical risk a patient may present with. Factors influencing this include awareness and insight of their condition and its risks, capacity to manage and take responsibility for those risks, life circumstances (Malcomess, 2005b). Assessing clinical risk would appear to inform the five core skills required for self-management (Figure 6) (Lorig and Holman, 2003).

Figure 6. Core skills for self-management

- Problem-solving
- Decision-making
- Resource utilisation
- Forming of a patient/healthcare provider partnership
- Taking action

(Lorig and Holman, 2003)

## KEY POINTS

- This pilot study suggests Care Aims has potential to support integrated team-working
- Care Aims may be more challenging to some professional staff groups than others and consideration should be given to the different professional cultures within the team
- Exploring the concerns of individuals may facilitate adoption of the philosophy of Care Aims, rather than a task-based approach
- Teams will need ongoing support to fully implement Care Aims following the initial training. Facilitated discussion to explore and develop their shared understanding may be beneficial

The organising themes identified that clinicians felt the paternalistic approach to care was not in the best interests of patients, and the Care Aims training had challenged them to think differently about this and work with patients to enable and empower them. The results also suggested that the level of change differed according to professional culture, in terms of how the relationship with patients was viewed (e.g. participatory or paternalistic). However, to support self-management, clinicians also have to overcome their anxieties about Care Aims.

The potential of Care Aims to support self-care was summarised by one clinician as:

*'It's about ensuring that you know and define your role and responsibilities with that patient. That patient is clear about what you can offer them and also where their own personal patient responsibility lies, as well in improving their own health condition'*

## Conclusion

This pilot case study provides an insight into the

impact of culture in one health care team during the implementation of Care Aims. This was a pilot case study so caution should be applied to the findings.

This team had recently started to implement the Care Aims and a longitudinal study comparing team culture pre- and post-Care Aims implementation may give further insight. Similar to previous studies, this case study has given a team member's perspective. To triangulate the data, patients could be asked to participate using a similar approach.

This case study suggests Care Aims has potential to support integrated team working and provision of integrated care. In this study, clinicians perceived Care Aims was a model designed to improve care for patients, could support professionals working together and could support self-management, although it would appear that there is potential for the team to work in a more integrated way. However, it is unclear whether it was Care Aims itself, or the training and discussion that took place, that enabled this team to develop and agree more consistent working practices.

Similar to previous studies, this study has shown how team and professional culture can influence how team members work together and provide care in an integrated way. As such, Care Aims may be more challenging to some staff groups to implement. [NHGM](#)

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