



# University of HUDDERSFIELD

## University of Huddersfield Repository

Ross, Angela

Professional identities, inter-professional relationships and collaborative working : an investigation using a constructivist phenomenological approach

### Original Citation

Ross, Angela (2005) Professional identities, inter-professional relationships and collaborative working : an investigation using a constructivist phenomenological approach. Doctoral thesis, University of Huddersfield.

This version is available at <http://eprints.hud.ac.uk/4609/>

The University Repository is a digital collection of the research output of the University, available on Open Access. Copyright and Moral Rights for the items on this site are retained by the individual author and/or other copyright owners. Users may access full items free of charge; copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational or not-for-profit purposes without prior permission or charge, provided:

- The authors, title and full bibliographic details is credited in any copy;
- A hyperlink and/or URL is included for the original metadata page; and
- The content is not changed in any way.

For more information, including our policy and submission procedure, please contact the Repository Team at: [E.mailbox@hud.ac.uk](mailto:E.mailbox@hud.ac.uk).

<http://eprints.hud.ac.uk/>

# **Professional Identities, Inter-professional Relationships and Collaborative Working:**

**An investigation using a constructivist phenomenological approach.**

**ANGELA ROSS**

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

**The University of Huddersfield**

June 2005

## **Abstract**

This research project sets out to explore, analyse and theorise the way district nurses and social care workers construe their identity, and their relationships within the changing context of collaborative projects. Unlike previous research in this field, this project offers an alternative, relational view of exploring professional identities and inter-professional relationships. The research adopted a constructivist phenomenological approach drawing upon the theories of personal construct psychology (Kelly, 1955) and existential phenomenology (Merleau Ponty, 1962), as elaborated by Butt (2004, 1998).

The project consists of three studies. The first empirical work is a preliminary study using individual interviews of students undertaking degree courses in community nursing or social work. This study is concerned with examining the students' concepts of what it means to belong to a particular occupational group and the influences that shape their ideas. Using focus groups and individual interviews, the second study explores how district nurses and social care workers negotiate their identity as a result of national changes and service developments. The final study explores inter-professional relationships of individual district nurses and social care workers, using reflective interview techniques (Hargreave, 1979, Salmon, 2003).

In keeping with phenomenological methodology, data was analysed using template analysis (King, 2004). A number of emerging constructs were identified that highlight the personal, historical and contextual influences upon professional role construction and inter-professional relationships, notably: visibility and recognition, role flexibility and rigidity. In particular the findings illustrate how professional identity is constructed, challenged, and reconstructed, through on-going interaction. To facilitate role re-construction and sociality, the reflective interview techniques were adapted and extended to encourage practitioners to reflect upon their every-day practice and relationships when working in a multi-disciplinary setting.

## **Publications arising from the project**

1. Ross, A., King, N., and Firth, J (2005) Interprofessional relationships and collaborative working: encouraging reflective practice. *Online Journal of Issues in Nursing*, **10** (1) Manuscript 3. Available: [www.nursingworld.org/org/ojin/topic26/tpc26\\_3.htm](http://www.nursingworld.org/org/ojin/topic26/tpc26_3.htm).
2. King, N., and Ross, A (2003) Professional identities and interprofessional relations: Evaluation of collaborative community schemes, *Social work in Health Care*, **38** (2): 51-72.

# Contents

	<b>page</b>
<b>Chapter 1. Introduction</b>	<b>2</b>
<b>Chapter 2. Collaboration and Inter-group relations</b>	<b>10</b>
The collaborative movement	11
Defining collaboration and inter-professional working	11
Collaboration as a process	12
Collaboration as group work	13
Collaboration as a pluralistic working concept	14
Application to community services	16
Social identity theory	19
Embedded inter-group relations theory	22
Psychodynamic-systems theory	23
Towards an existential understanding	26
Professional identity as negotiated interaction	28
Glossary	32
<b>Chapter 3. Professional, professionalism and the development of the care professions</b>	<b>33</b>
Professionals and professionalism	33
Early social history of nursing and social care	36
Development of nursing	39
District nursing	41
Moving forward	44
Image and role	45
Development of social work	46
Role and image	51
Moving towards interprofessional working and education	53
<b>Chapter 4. Epistemology and methodology</b>	<b>57</b>
How do we know what we know?	57
Personal construct psychology	60
Phenomenology	60
Methodology	62
Preparing for data collection and analysis	65
Epoché	66
Bracketing	66
Reflexivity	68
Recording and documenting data	69
Developing useable convention	71
Analytical strategy	72
Verification of analysis	74
Quality and usefulness of qualitative research	75
Overcoming ethical nightmares	77

<b>Chapter 5. Study One:</b>		
<b>Beliefs and learning experiences of student care professionals Part one: Introduction and methodology</b>		<b>88</b>
Methodology		88
Background		89
The school of community health and social care		90
Negotiating access		92
Introducing the participant groups		93
Data collection		97
Semi structured individual interviews		98
Analysis		103
• Creating the template		104
• Summary of codes		107
<b>Chapter 6. Study One:</b>		
<b>Beliefs and learning experiences of student care professionals Part two: The findings and discussion</b>		<b>112</b>
Beliefs about professional identity		112
Defining professional boundaries and roles		128
Professional socialisation and learning experiences		139
Beliefs about joint working		145
Discussion		155
• Historical and cultural influences		155
• Key aspects to professional identity		158
• Anticipating events		160
• Understanding others in joint working		161
<b>Chapter 7. Study Two:</b>		
<b>The development of an out of hours district nursing service. Part one: Introduction and methodology</b>		<b>167</b>
Background to the study		168
Methodology		172
Data collection		172
Key informant interviewing		173
Focus groups		174
Sampling and organizing focus groups		175
Negotiating access		177
Developing the interview guide		181
Analysis		187
• Writing the story		187
• Template analysis		190
• Final template		192

<b>Chapter 8. Study Two:</b>	
<b>The development of an out of hours district nursing service</b>	
<b>Part two: Findings and discussion</b>	<b>193</b>
<u>A story of change: Background</u>	193
Moving bases	196
Developing working together	199
Divisions	200
Working relationships with homecare out of hours service	204
Utilisation of the service	206
Summary	207
<u>Template analysis of staff responses</u>	209
National changes to health and social care boundaries	209
Role extension and erosion	210
Reactions to local service changes	217
Relationships between services	220
Discussion:	225
• Coping with change	225
• Adjusting to change	229
• Re-construing constructs	232
• Re-construing resistance to change	234
• Summary	235
<b>Chapter 9. Study Three:</b>	
<b>The study of Interprofessional constructs and networks</b>	
<b>Part one: Methodology and reflective interviews</b>	<b>238</b>
Methodology	239
Interview techniques	240
Sampling	242
Negotiating access	243
Introducing the participants	245
The interview experience	248
Case studies:	
1. District nurse	249
• Scenario	250
• Analysis and template	251
• Findings	254
2. Senior practitioner	257
• Scenario	258
• Analysis and template	259
• Findings	262
The responses to the interview experience	266

<b>Chapter 10. Study Three:</b>	
<b>The Study of Inter-professional constructs and networks</b>	<b>269</b>
<b>Part two: Findings and discussion</b>	
Analysis	269
Findings	271
• Teamwork	271
• Characteristics of good teamwork	274
• Hindrances to inter-professional relationships	286
• Finding solutions	293
Discussion	298
• Being there	298
• Personal sacrifice	299
• Flexibility and sedimentation	300
• Understanding and anticipating roles	303
<b>Chapter 11. Concluding reflections</b>	<b>309</b>
Re-construing professional identity	310
Agency and change	314
Understanding inter-professional relationships	316
Developing practice	319
Strengths and limitations	322
Final Note	325
<b>References</b>	<b>327</b>
<b>Appendices</b>	<b>354</b>
1 Examples of reflexivity	355-7
2 Letters	358
3. Ethics	360-1
4. Contact forms	362
5. Interview schedules	363-6
6. Composition of focus groups	367-376
7. Template analysis:	377
Out of hours district nursing service	
8. Reflective network layouts and Salmon Lines	378

<b>LIST OF FIGURES</b>	<b>page</b>
Fig.1 Barriers to Inter-organisational Collaboration	16
Fig.2 Transcription Conventions	72
Fig.3 Summary of Template Analysis	74
Fig. 4 Presentations	79
Fig.5 Interview Guide	100
Fig.6 Data set Analytical Strategy- Study 1	104
Fig.7 Beliefs about Professional Identity	108
Fig.8 Professional Boundaries and Roles	109
Fig.9 Professional Socialization and Learning Experiences	110
Fig.10 Beliefs about joint working	111
Fig. 11 Details of participants	180
Fig.12 Analytical Strategy – Study 2	190
Fig.13 Final Template of Focus Groups – Study 3	192
Fig.14 Template: Maxine	251
Fig. 15 Maxine’s Interpersonal Layout	252
Fig. 16 Maxine’s Salmon Line	253
Fig. 17 Template: David	259
Fig. 18 David’s Interpersonal Layout	260
Fig. 19 David’s Interpersonal Layout	261
Fig. 20 Interpersonal Networks Data set and Analytical Strategy	269
Fig. 21 Interprofessional relationships template	270

## **Acknowledgements**

I would like to take this opportunity to thank all those who participated within this project - the students the district nurses and the social care workers were integral to the development of this thesis. In particular I would like to thank Nigel King, Janet Firth and Phil Salmon for all their support and supervision. Thanks also for Ruth Moore, Dawn Lawson, and Phil Derrol for their encouragement and feedback on earlier drafts. Finally to my friends and family who have supported me through to this stage. In particular, to Robin Stevens and Helena Ferro who painstakingly proofread my work. To Mark (my husband), Jon and Lizzey (my children) who without their patience and encouragement this project would not have been completed.

***Remember Phil Salmon***

## **Chapter 1.**

### **Introduction**

#### **Setting the scene**

Over the past two decades the National Health Service and Social Services have undergone immense managerial restructuring and unprecedented organisational change, in response to the increasing demands and costs of health and social care. During the early stages of the modernisation process the concept of quasi markets has played a key role (Griffiths, 1988, DOH, 1989, 1997, 1998). This has brought an increase in managerialism and consumerism that has not only challenged the autonomy and hegemony of the caring professions, but has also questioned the definition of professional roles and working boundaries between health and social care (Fournier, 2000, Petrioni and Petrioni, 1996). Recent further attempts to dissolve boundaries and provide cost-effective services, have focused upon inter-professional working, partnership and community-led care (DOH 1999, 2000, 2002). During such a time of momentous change for community nursing and social care staff, I propose that it is essential to re-examine the neglected concept of professional identity, how professional identity is constructed and its influence upon inter-professional relationships in joint working situations. I will define professional identity from a constructivist phenomenological perspective through the reading of Personal Construct Theory, as elaborated by Butt (1997,1998). From this position, I view professional identity as constructed through on-going interactions, whereby people recreate and negotiate role performance with each social encounter (Butt, 1996).

## **Significance of Professional identity**

I first became aware of the complexities of joint working and professional identity from my experiences as a research assistant, evaluating a rapid response project in the North of England (1999-2000). The evaluation of the project revealed a number of problems between social workers and district nurses associated with their professional identity and roles (King, Ross, Firth and Avarelo, 1999). The most significant were the following themes; inequity in decision-making and accountability and a general uncertainty over professional boundaries. Overall, patchy communication and under-developed relationships were identified which resulted in social workers feeling their contributions were overlooked and district nurses feeling excessively burdened with responsibility (King and Ross 2001). However, it transpired that this was not a unique situation. Earlier studies of joint working within the health/social care sector reported similar inter-group power conflicts associated with professional accountability, responsibility and distribution of resources (Rummery and Glendining, 1997, Hudson, 1998, Biggs, 1993, 1997). In spite of the government response (DOH, 2002), integrated care between these services remains slow and tentative at operational level (Poxton, 1999, Burch and Boland, 2001). It is evident then, that restructuring or re-modelling procedures and services do not provide the solution, therefore a complementary 'relational approach' to the study of inter-professional working is warranted (Hornby and Atkins, 2000), in terms of professional identity and how this is negotiated in practice.

## **Developing the study**

Following on from my first evaluative study, I became increasingly interested in the ways district nurses and social service staff re-constructed their identity in response to the

various developments that were taking place around them; in particular, to joint working practices at operational level. Joint working at this level appears to create situations where professional identity and traditional roles are no longer prescribed, but have to be actively worked out and negotiated between the differing professionals involved with care delivery (Fournier, 2000, Gelman, White, Carlson 2000). Often, professional groups are forced to redefine their identity and to reconsider their individual purpose, expertise and value to the wider organisation (Petroni and Petroni, 1996). For some practitioners, traditional roles and distinctive forms of thinking hold particular value and shape their sense of what it is to be a nurse or a social worker and therefore, any alteration to distinctive practices or blurring of traditional roles will be perceived as threatening and they will be slow or resistant to changes (Biggs, 1997). From this understanding of collaborative working, the following questions arise: How do professionals construe their identity within such a fluid-working context as collaborative working? What does it mean to be a professional in the changing context of health and social work? What can contemporary approaches tell us about professional identity in this given context? What relevance do contemporary theories hold for professionals in joint working situations? In an attempt to approach these questions the overall aim of this thesis is to explore the ways professionals construe their identity within the changing context of collaborative working.

To investigate this phenomenon I was unhappy with cognitive and structuralist approaches to identity and the way these theories position individuals within contemporary society. Not only do such theories perpetuate the traditional static

conceptions of what it is to be a professional, but also they fail to acknowledge the potential resilience of people experiencing dramatic occupational changes. Moreover, in seeking to resolve dilemmas, earlier organisational literature and social constructionist approaches often disempower the individual either by imposing mechanistic models (Cox, 1995), or by emphasising the control of the social world upon the individual (Abbott, 1998). Therefore in order to steer clear of essentialist and deterministic accounts I sought phenomenological and constructivist theories to underpin this study.

My primary concern here is to understand, and articulate how individuals within occupational groups construe and organise their world in a meaningful way. To approach this study, existential phenomenology and personal construct theory (PCT) held particular appeal because of their orientation towards people and subsequent relationship to the world. From the reading of PCT, Kelly (1967) empowers the individual by describing the person as a creative 'meaning maker', 'self inventing' (Butt 1997) and in action with social forces rather than subject to them (Mair, 1979 Butt, 1998). This dialectic relationship between the person and the world is further clarified by the work of Merleau Ponty (1962). Action here is viewed as an embodiment (bodily expression) of purpose and intention; the person structures the world as well as being influenced by it. Following on from this understanding, the concept of constructs central to PCT, can no longer be defined as a mere cognitive activity prior to action, constructs therefore, will be defined as 'construing in action' (Butt, 1997); referred to by Merleau Ponty (1962) as a 'pre-reflective' activity.

Drawing from the aforementioned theories, this research will attempt to investigate the notion of professional identity by engaging with the ways professionals construe their identity through their dialogue and their relationships in practice. The location is pertinent to the study and will largely take place within a community in the north of England that is undergoing specific developmental and organisational change. The research methods for this study will be culled from a range of phenomenological and hermeneutic techniques, sought to uncover meanings that specific professionals bring to collaborative situations. Interaction and dialogue being the key features of this study meant that focus groups, individual interviews, and interpersonal networks (Hargreaves, 1979) were the most appropriate methods of data collection. For analysis of the data, I have utilised a 'template analysis' in keeping with the phenomenological approach, which provides the breadth and specificity for organising groups of data (King, 2004, Crabtree and Miller, 1999). Consistent with the theoretical approaches, interpretation of the data will be in terms of dimensions of action rather than cognitive structures (Butt, 1997).

### **Research Focus**

The intention of this study is to make explicit the meanings that district nurses and social care workers bring to collaborative projects. In so doing, this thesis attempts to provide a contemporary understanding of the notion of professional identity and the complex relationships within joint working projects. To facilitate professionals experiencing ongoing organisational change, understanding of the relationships between personal and social construction of professional identity is perceived as necessary and more powerful than explanation or prediction.

**Overall aim:**

**To explore the ways district nurses and social care workers construe their identity within the changing context of collaborative working.**

**A brief outline of the thesis.**

To understand the relationship between organisational transformation and the implications for professional identity, I will explore in Chapter 2 the different meanings of collaboration and inter-professional working within organisational life. In so doing I will present the differing structural and organisational approaches to professional identities and their limitations in current working situations. Following on, I will introduce an alternative constructivist phenomenological stance, deemed more appropriate to defining professional identity and role development in a changing climate.

From an examination of earlier literature Chapter 3 will explore the historical development and professionalisation of district nursing and social workers. I will review how earlier writers define professional status and present the debate concerning the professional classification of social workers and nurses. Questions will be raised as to whether the underlying values of being a professional, with the formation of boundaries are conducive to inter-professional working.

Chapter 4 will draw together the aims of the empirical work of this thesis and will provide an overview of the methodological position. The aim of the study is to focus on

the meanings that district nurses and social care workers bring to the events. The research is designed to engage with the ways professionals construe their identity through their dialogue and their relationships. This project requires the utilisation of various hermeneutic and phenomenological tools for the different studies. Therefore, details of the different research tools and rationale of specific methods will be discussed within the appropriate empirical sections of this thesis (Chapters 5-10).

Chapter 5 and 6 presents a preliminary study of district nurse and social work students within the university setting. This study is concerned with examining the student concepts of what it means to belong to a particular occupational group and the influences that shape their ideas. During individual interviews, students discuss their values roles, occupational training and their work experiences in comparison with other professional groups. This study highlights the need for joint training between health and social services and explores how the principles of Kelly's sociality corollary might encourage practitioners to understand the roles of others in a joint working situation.

Chapters 7 and 8 investigate how district nurses and social workers negotiate, construct and reconstruct their professional identity in a particular joint working context which is experiencing political and developmental change. The impact of change is explored in terms of a person's professional identity, their roles and working relationships in everyday practice. To inform our understanding of professional identity and change I have drawn upon Kelly's corollary of experience and choice (1963, 1977).

Chapter 9 and 10 continue within the same context but attempt to examine further professional identity within the framework of individual interpersonal relationships. Individual district nurses and social care workers are encouraged to reflect upon their joint working practices using a reflective interview tool (adapted from Hargreaves 1979 and Salmon, 2003). Furthermore, I found that through the reflective technique practitioners were able to explore alternative ways of improving relationships with other professionals and their clients.

Finally, chapter 11 discusses the findings in relation to previous research. This chapter reflects upon the emergent perceptions of professional identity and collaborative working as presented in the previous chapters (5-10), and on the implications these have for practice and future research. Comparisons will also be drawn between the literature and the conceptual ideas that I have generated during the course of this project.

## **Chapter 2.**

### **Collaboration and inter-group relations.**

The purpose of this chapter is to review the current position of theoretical and empirical research with regard to collaborative working for social service and district nursing staff. The main focus of this inquiry surrounds the issues of inter-group relations between these specific occupational groups known as 'care professionals'. This chapter will focus specifically on the theories and approaches that underpin the notion of collaboration. Drawing upon both social and organisational psychology (specifically work group psychology), I will first enlarge upon the conceptualisations of collaborative working, following on with the possible implications these notions may have upon health and social care workers. Secondly, I will critically examine the literature of inter-group relations theories from social and organizational psychology. Finally, I will argue for the concept of collaboration to be viewed in a broader context other than the processes alone, since collaboration raises the question of identity, occupational boundaries and meaning for the professionals involved.

#### **The collaborative movement**

The buzz words, 'collaboration', 'inter-professional', 'joint working' and 'partnerships', signify a pragmatic change in the approach towards community care delivery and working relationships. Since the Griffiths report (1988), collaborative care continues to be extolled by government legislation (DOH. 1990, 1997, 1998, 2001a), propagated by organisational managers and incorporated into the values of professional (nurses and social workers) bodies (NMC, 2002, CCETSW, 1990). It appears that many managers

and practitioners have received collaborative working as the key to the process of a 'much needed' organisational change (Beer, 1993) and as an instrument for a wider change in approach to professional practice. For it is widely believed that collaborative working between health and social services enables professionals to achieve a 'cost effective', 'needs led', 'patient (user) focused', 'seamless service' (Leathard 1994, Griffiths, 1988). In spite of the widespread support for collaborative practice, definitions and interpretations of joint working at operational level are less than clear, and may have contributed to the number of difficulties reported (Poxton 1999, Burch, and Borland, 2001).

The differing interpretations of collaboration that are brought to joint working events have implications for the outcome of the event for those who are involved with the interaction, and for how this experience shapes future professional identity and role at practice level. Exposing the differing interpretations and meanings between those involved in joint working events makes it possible to provide a more 'open' and productive dialogue between the occupational groups (Ovretveit, 1994). It is therefore the purpose of this thesis to explore the meanings and interpretations that district nursing and social care staff bring to joint working events. Before I proceed further I will clarify and examine collaborative working from organisational, health and social welfare literatures.

### **Defining collaboration and inter-professional working**

The concept of collaborative or inter-professional working within the health and social context becomes increasingly difficult to define and is associated with a multitude of

other terms. The lack of definitions within organisational or public service literature emphasises the complexities and subtleties surrounding the concept. Often meanings blur or expressions change, to describe the expanding and developing range of professionals involved in the caring arena (Biggs, 1997). To bring clarity to a host of differing meanings I have utilised the term inter-professional to describe collaborative relationships between two professional groups. In the case of this project this involves the relationships between district nurses and social care staff. Multidisciplinary working refers to teams consisting of members from several different disciplines from within the same professional group. I have provided a list of terms used in a glossary at the end of this chapter. For the purpose of this project I will now further explore the concepts of collaborative and inter-professional working.

### **Collaboration as a process**

As a starting point, collaboration is often used as a generic term in health literature to describe various forms of joint working between different occupational groups or individuals.

*'A relationship between two or more people, groups or organisations working together to define and achieve a common purpose'*

(Hornby and Atkins, 2000, p.12).

The term here, denotes a goal orientated relationship, - a *modus operandi*, an inter-group process (Leathard, 1994, Guzzo, 1996) that may be formed at different working levels, both across and within organisations. For example, at strategic level (Pettigrew, 1992), operational management (Ovretiet, 1994), or at client 'face work' level (Hornby and

Atkins, 2000). Often joint-working projects involve multiprofessional or inter-professional teams, where members from different professional groups agree to work together for a specific venture (Biggs, 1997a), for example medical, nursing, social and paramedical staff providing home support and rehabilitation for newly discharged patients .

### **Collaboration as group work**

The intensity and closeness of collaborative working between health and social care workers varies, and is subject to the type of project, the level of joint working between the organisations (Hudson, 1998) and how this project is interpreted between the practitioners (Miller, Freeman and Ross, 2001, Biggs, 1997a). Generally, joint working at operational level usually takes the form of a work group situation, where the work task or contribution is 'what the members do not as individuals but as members of the group' (Guzzo, 1996, Overetiet, 1994). Joint working between nurses and social care staff for example, is often used to describe a working alongside, delegating care to other professionals according to their fields of expertise. For instance, the care of the elderly would involve home care staff visiting the elderly to provide personal care such as washing and toileting. The district nurse would visit to attend to other needs such as injections and dressings or to monitor long-term conditions such as diabetes. Depending on the care required by the client, relationships between practitioners may be transient and short-term.

The focus of this thesis however, refers to inter-professional working, a specific form of collaboration where two diverse occupations 'make a different complementary contribution' – a *modus vivendi*, as part of a group work situation. In this case the professional groups involve district nursing and social care staff. Although they partake in multidisciplinary working by co-ordinating care with other professionals, district nursing and social work staff have a specific relationship in terms of delivering care to 'vulnerable' groups within the community (Poxton, 1998). An example would be, maintaining the elderly in their own home by providing long-term health and social care.

### **Collaboration as a pluralistic working concept**

A further examination of the concept of collaboration derives from organisational literature and takes a pluralist approach based upon co-operative values (Kraus, 1980). From this source, collaboration is said to encourage flexibility of occupational boundaries, collective decision-making, shared power and non-hierarchical authority. Ideally, power relations between professions become based upon knowledge or expertise as opposed to role function or assigned status. Furthermore, social order, structures, identities and group membership are expected to emerge out of the relationship process, rather than being exerted by a hierarchy (Hoskins and Morley, 1991). Collaboration then, is more than just a way of working, but has implications for the way public services are structured and managed.

According to Kraus (1980), effective and sustainable collaborative working requires the organisation to have few bureaucratic layers and occupational groups to become highly

interdependent with other professionals and their organisation. Other sources confirm that interdependency is the key to the creation of new structures and ways of working. Skills and roles will be guided by 'help' from other professionals rather than through organisational procedures (Hosking and Morley, 1991). One obvious hurdle to overcome is the application of an interactional way of working and organising to long-standing bureaucratic organisations, such as the NHS and the department of Social Services.

The underlying philosophy governing many health and social reforms, and public service management reforms too, have been based upon unitarian management and Weber's bureaucratic model of organising. Within this organisational model, 'specialisms' and hierarchy are encouraged and believed to be the key to commitment and smooth management (Rollinson, Bradfield and Edwards, 2002). Staff have clearly defined roles and relationships, controlled and formalised by a hierarchy (Argyle, 1989). A highly rigid structured approach within the health and welfare services has meant professionals are largely kept separate with little cross-boundary collaboration. Therefore, accommodating collaborative working within the NHS and DHSS has meant on-going national and local restructuring (DOH, 1999, 2000), as well as changes in how professionals negotiate their work roles and purposes with other occupational groups (Pietroni and Pietroni, 1996, NMC, 2002). Some of the main barriers identified by earlier writers are listed in the box below.

**Fig 1. Barriers to inter-organisational collaboration**

**1. Structural:**

- Fragmentation of service responsibilities across agency boundaries
- Inter-organisational complexity and non-coterminosity of boundaries
- 

**2. Procedural:**

- Differences in planning
- Differences in budgetary cycles and procedures

**3. Financial**

- Differences in funding mechanisms and bases
- Differences in the stocks and flows of financial resources

**4. Professional**

- Differences in ideologies and values
- Professional self-interest and threats to autonomy and domain
- Threats to job security
- Conflicting views about clients' and consumers' interests and roles

**5. Status and legitimacy**

- Organisational self-interest
- Differences in legitimacy between elected and appointed agencies

(Hardy et al,1992, cited in Hudson 2000,p.254)

**Application to community services**

The theory advocated by Kraus (1980) was written largely for application within a corporation rather than across organisations or professional groups. With this consideration, collaborative working between health and social work requires more than just fine-tuning structures and global values. First, the keys to effective collaborative working between district nurses and social workers are said to be relational (Hornby and Atkins, 2000). One of the hindrances to the relational process for district nurses and social workers is distance, both structural and perceptual. District nurses and social workers in the community tend to work in isolated groups and frequently do not work from the same geographic location. Furthermore, the separateness encouraged by professionalisation and the differences in the way the two organizations manage their

work, has meant that the practitioners have had little understanding of each other's roles when it came to collaborating or sharing care (Hutchinson and Gordon, 1992, Hudson, 2000).

Secondly, there has been little room for flexibility of roles for health and social care professionals. It is not always possible for caring professions to reconstruct their roles or identities, as their values and responsibilities are influenced by historic traditions, public expectations, and statutory requirements from the respective professional bodies. This I will return to more fully in the next chapter concerning professionalisation and professionalism.

Finally, the pluralistic approach to the area of conflict as part of the negotiating process appears restrictive and limited. Kraus highlights the inevitability of conflict only as a result of contrasting values, between a competitive philosophy and a collaborative philosophy. A further source of conflict for nurses and social workers arises as a result of their membership of the varying working groups and their commitment to their own professional body (Biggs, 1997). In these circumstances, how do professionals resolve the dilemmas between their own professional values and expectations and those of the multidisciplinary group? Where do professionals place their allegiance? For example, there is a concern amongst some social workers that if they were based within General Medical Practices, they may gradually lose sight of their social service priorities under the pressure of health objectives (Glendinning, Rummery and Clarke, 1998). The outcomes of such conflict may not always be constructive as inferred by other authors (Tetlock, 1994). Caring professionals may be reluctant to participate in joint projects and

withdraw further to rigid professional boundaries, as described in the health literature (Biggs, 1997).

To resolve the difficulties implicit in collaborative working, government reforms and strategic managers have largely drawn upon structural accounts based upon entitative approaches (Hoskins and Morley, 1991). The understanding here is that organisations are regarded as entities, possessing the values, motives, and identities shared by all. Often inter-group relations are conceptualised in mechanical terms in order to manipulate behaviour for the benefit of the organisation (Rollinson, Bradfield and Edwards, 2002, Johnson, 1993, Hartley 1996). Consequently the professional is thus reduced to an 'aggregate', an organisational property to be directed by the hierarchy (Harre, 1979). It is not surprising then, from the utilisation of such management approaches, that the implementation of collaborative working has been reported as slow and difficult (Poxton, 1998). Perhaps then the ethos of collaboration is incongruent with the 'entitative', competitive and manageristic values, currently employed by the health and social services. For collaborative working to be effective within the public services requires policy makers and key management to fully embrace the ethos as well as the collaborative process.

So far I have highlighted the concepts of collaboration and their implications for the formal structures of health and welfare services. To go a step further, collaboration is about relationship and forces organisations and professionals to reconsider their relationships with other occupational groups. Scanning the social psychology and

organisational literature, three prominent contrasting theories have paid particular interest to inter-group relationships. Those being social identity theory (SIT) embedded inter-group relations theory (EIRT) and more recently the comprehensive work of Hornby (1998) using a psychodynamic and systems approach. I will now examine their contributions in the light of furthering our understanding of collaboration in a working context. Following on I will propose an alternative existential approach to studying inter-group relations that will consider how practitioners construe their occupational identities and relationships.

#### **i. Social Identity Theory**

Social identity theory has guided much of the social psychological research conducted on inter-group relations. This widely researched approach has been applied to a number of social issues, organisational studies, and notably contributes to our understanding of the relational difficulties encountered between health and social workers. Social identity theory (SIT) is a cognitive theory drawing upon the work of Tajfel and Turner (1986, Turner, 1991) and the social comparison theory of Festinger (1954). A fundamental aspect of SIT is a focus on how individuals classify, identify and compare themselves with particular social groups. By comparing and categorising, the individual identifies and accentuates group differences (Hogg and Abrams, 1999), forming stereotypical descriptions of other groups and favourable impressions of their own group (Tajfel and Moghaddam, 1994). For instance, the more important a group is to its members the more bias they show towards their own group. This process not only enables individuals to

simplify and make sense of their world but also enables them to form a social identity, which will enhance self-concept, and self esteem (Abrams and Hogg, 1988).

SIT stresses the relevance of identity in relationship with other social groups. Although identity is described in, plausibly neat distinct cognitive categories, nevertheless the theory provides an interesting insight into cohesive groups, group ethnocentricity and the detrimental effects of categorisation (Sherif and Sherif, 1967). The influence of SIT is demonstrated through some of the health and social literature, where authors have identified a number of similar sources of conflicts and rivalry to those that were revealed in early conflict studies (Sherif, 1981, 1964). For instance, conflict is most prominent between groups where there is scarcity of resources (Poxton, 1999, Biggs, 1997a). Consequently, there have been a number of strategies suggested by health and welfare literature. For example, providing super-ordinate goals, organising services to increase contact between the groups (Hudson, 1998) and the recommendation of pooling resources (DOH,1998, Rummery and Glendining, 1997, Higgins, Oldman and Hunter 1994).

There are however, a number of problems associated with the concepts of SIT; I shall now outline a few in relation to the study. First, an over-emphasis placed upon an identity gained largely through self-definition and categorisation. There are situations where others inside and outside the group define the individual or group independently of self-definition. For instance the public may identify nurses with the image of Florence Nightingale attending to personal needs at the bedside, whereas the nurses themselves may identify themselves as progressive managers, coordinating health care across a

population. Outside influences may therefore, have considerable bearing on shaping or constraining the occupational activities.

Second, the conclusions drawn from earlier studies need to be considered within the socio-historical context. Early inter-group studies are based upon 'concocted' groups either in laboratory settings or in 'closed' group situations (Hartley, 1996), where participants do not have either a historical or social relationship with each other. Nurses and social workers have a professional and organisational history as well as an individual history, which they bring to their working events.

Third, in experimental groups, participants are constrained to stay within the group and experimental setting, whereas in a working context, there are constant exchanges and movement between different groups. An organisation like the NHS draws upon a diverse number of occupational groups across a wide geographical area. Professionals may develop various forms of contact and relationships within their own group, as well as with the other professional groups.

Finally, the theory places an emphasis upon the inevitability of conflict between diverse groups. Collaborative working need not always be associated with conflict as there are times and situations where professionals do work together in harmony. Therefore, an adequate inter-group theory should account for the successes as well as the failures of inter-group relationships (Johnston and Hewstone, 1990). Furthermore, analysis needs to acknowledge the value of the person as well as the collective, to take into account inter-

group dynamics, and the social context in which the groups are located (Nkomo and Cox, 1995).

## **ii. Embedded Inter-group Relations Theory (EIRT)**

Perhaps a more fruitful approach to inter-group behaviour is Embedded Inter-group Relations theory (Alfered and Smith, 1982). Arising out of organisational studies, the theory attempts to integrate context with inter-group processes. Unlike SIT, the group and social networks form the primary level of analysis. From this perspective, groups are viewed as 'embedded' within social systems and in organisations, which in turn are embedded in the environment. The notion 'embedded' refers to the relationship between groups, their social and historic influences, and how these are reflected through group perceptions and functions. The theory argues that all people have their emotions, cognitions and behaviours shaped by multiple group memberships, from within and without the organisation. Through the various group contacts, individuals may embrace multiple identities, which may be in operation at anytime. This raises the question, in what situations do particular group behaviours or identities manifest themselves?

In answer to this question the theory argues that the particular group identities displayed in any situation depend on the following situations; the groups that are represented, the issues that are critical in the inter-group exchange, and the hierarchical level at which the exchange takes place. In a multidisciplinary care situation, for example, where the professional group identities are salient, each individual will be seen as representing their respective occupational groups. In other work group situations, an individual may behave

and take on similar values of the particular group they have been interacting with. For instance (as I have already mentioned earlier), it is thought that if social workers are placed individually in a general practice isolated from members of their occupational group, they will gradually abandon their social work ideals and take on the values of those they are working with (Hudson, 1999a).

Embedded inter-group relations theory holds particular appeal to some social researchers, because it takes into account the variability and multiplicity of identities that are shaped by our historical and social systems, and by differing group memberships. Also, EIRT contributes to our understanding of group behaviour in terms of how group valuations and group memberships may change according to type of exchange, context, and power positions within the organisation. However, the concept of the person remains lost within the group as there is a tendency to view the individual as a passive unit that is subject to the social environment, rather than working with it and potentially shaping it (Burr, 2002).

### **iii. Psychodynamic –systems theory (Hornby, 1998)**

In an attempt to embrace a psycho-social relational stance, Hornby (1998, Hornby and Atkins 2001) proposed an interesting combination of psychodynamic and systems approach to understanding professional identity within collaborative relationships.

Hornby draws upon the systems approach to explain the person's connectedness with their social world. The person is described in terms of a dynamic organism, who is 'a system within a system' and is capable of growth and change. When it comes to

exploring the complex professional identities and relationships, Hornby adopts psychodynamic concepts and therefore attributes relational difficulties to problems at an individual unconscious level. Here the individual identity comprises a core-identity and an extended identity. The core identity remains stable throughout life and is based upon personal characteristics, capabilities and physical attributes. In contrast to the core identity, the extended identity is variable and is modified throughout life according to exposure of differing groups, culture and education. Similar to psychodynamic theory, early upbringing and social groups influence the development of the individual and contribute to how secure a person is with their individual identity. For example, a strong affiliation to a group identity, that is often displayed by nurses towards their profession, is viewed as a substitute for an insecure or poorly 'integrated' individual identity (p. 102-103).

The work of Hornby is a retrospective and personal reflective account of working groups, gathered from case studies, interviews and observations of case conferences, during her time as a psychotherapist and social worker. It provides an interesting if not a complex account of working relationships. Also, the literature includes practical insights into ways of working, and for many practitioners this is likely to be an invaluable tool, which aids meaningful reflection upon working practice. However, in spite of the attempt to provide a relational account of collaborative working, there is a tendency to attribute 'root problems' to inherent psychological factors. People's reactions and relationships are often interpreted and labelled in terms of personal angst and defence mechanisms. Consequently, such an approach may hinder the reader from exploring alternative

interpretations to an actor's behaviour. For example, a social worker may be reluctant to share information about a client to a district nurse. From a psychodynamic viewpoint (and perhaps from the nurses) this may be interpreted as working defensively to protect one's own professional boundaries as a result of some personal insecurity, whereas from the social worker's viewpoint she may be construing her actions in the light of protecting client confidentiality.

From the above theories the concept of identity is essential to the understanding of inter-group behaviour within an organisation. Both SIT and EIRT offer interesting insights about the individual and the way a group responds, but they seem to imply that group identities and personal identities are separate (and sometimes opposing) processes (Taylor and Moghaddam, 1994, Hartley, 1996, Hornby and Atkins, 2001). In spite of Hornby attempting to study the person in relation to their world, psychodynamic and systems theory manages to compartmentalise the individual without viewing the person and their world as a whole.

Moreover, the problem that lies at the heart of these approaches is related to the hotly debated questions concerning personal agency. That is, to what extent do we personally construct and determine our own lives, and to what extent does our environment shape us? Much of organisational literature rooted in cognitive theories suggests that the person largely shapes their social world and therefore, neglects to consider contextual influences. To the other extreme, those theories that attempt to consider social forces, such as system theories, reduce the individual to a marionette, whose puppeteer is their social

environment. Therefore to help us to comprehend the complexities of professional identity and the relationships between practitioners, we need to overcome these dualistic barriers by understanding the person not as a compartmentalised being or as 'an aggregate' (Harré, 1979), but in terms of a meaning maker and a co-creator (Kelly, 1955) -creating their world as well as created by it.

### **Towards an existential understanding**

I contend that a constructivist phenomenological approach, drawing upon the theory of Kelly's personal construct psychology (1955), offers an alternative and essential insight into the study of professional identities and inter-group relations. From this perspective the uniqueness of the individual is acknowledged, as well as the way the person is connected with their social world- as beings in the world. Behaviour then, is no longer regarded deterministically by inherent or social factors, but is negotiated through role interactions and relationships between people (Butt, 2004, 1996). I will now outline the basic principles of PCP and phenomenology, as I believe it provides a useful way of understanding how district nurses and social workers construe their world and their joint working experiences, a way that is lacking in many inter-group and identity studies.

I would emphasise at this point that initially Kelly did not fully recognise the similarities between PCP and phenomenology, as he construed phenomenology as a type of subjective mental introspection (Kelly, 1955, p.173, Butt, 2004b). Because of Kelly's limited reading of phenomenology, it is quite possible that he was unaware of the existential approach taken by Merleau Ponty (Holland, 1970). Nevertheless, it is through

the reading of Butt (1998, 2004a, 2004b) that we have come to appreciate the links between these two theories. I have explored the similarities of these theories in Chapter four.

Kelly contributes to our understanding of identity and roles through the concept of 'constructs', which are seen as templates through which an individual organises, understands and anticipates events (Kelly, 1955). Personal constructs are bipolar and represent dimensions of meaning, for instance in some situations I may view people in terms of whether they are 'helpful/unhelpful' or 'kind/unkind'. However, these constructs are not fixed labels but are changing and evolving as they are '*tentatively tried for size*' (Kelly, 1955 p.12) and tested. This may be understood as hypotheses that we put forward in our social encounters, which are then either confirmed or refuted and then revised accordingly. From our experiences we have developed a whole repertoire of unique constructs, which we hierarchically organise into systems and subgroups that '*embody subordinate and superordinate relationships*' (p.12). For example, the above constructs may be subordinate to my superordinate construct of 'caring'. I would add, my notion of caring may be regarded as unique but I have drawn upon ways of construing from the values and experiences that are available to me from the surrounding culture.

Although personal constructs are constantly changing there are 'core' constructs that we may be reluctant to alter, because they give us a sense of stability and '*maintains (his) our identity and existence*' (Kelly, 1955, p.482). 'Core' constructs comprise of superordinate constructs that are arranged according to how significant they are to a

person's sense of identity. These are described by Kelly as '*not too permeable*', which simply means that a person may not be willing to embrace new elements into their way of thinking, because this may lead to revising their whole construct system. Consequently, altering our core constructs may be perceived as threatening to our sense of being, whereas alteration to a 'peripheral' construct may not impact upon our sense of identity (du Preez, 1979). Therefore, it follows that altering core constructs and roles in the context of joint working may have implications for the way practitioners construe their professional identity and their relationships with other professionals.

Also, Kelly (1955) and Merleau Ponty (1962) argue we are embodied beings within the world. That is to say our constructs and ways of thinking are not confined to cognitive activity, but often we express ourselves and communicate meaningfully to others through bodily gestures and postures with no prior deliberation. Butt (2004, 1998) goes on to describe how much of the time we recognise and anticipate each other's intentions and actions in an effortless 'pre-reflective', unconscious way. It is only when there is an interruption to the flow of our interactions with people that our actions and thoughts are brought to our awareness. For example, a misunderstanding during a conversation with a friend may cause an argument that was unexpected. We may then reflect upon our actions that led up to that event.

### **Professional identity as negotiated interaction**

Drawing upon a constructivist phenomenological perspective then, professional identity is viewed as constructed through interactions and relationships between people. Therefore

it is not an unchanging and predetermined state but it is an on-going process in action, whereby people recreate and negotiate their role performance with each social encounter' (King and Ross, 2003, p.54.). Although identity is viewed as flexible and individually interpreted, professionals may not always be free to construct their identity in any form they choose. To an extent they are tied to their past and to the expectations of those around them (Merleau Ponty, 1962). There are historically and culturally embedded roles, values and statuses that may have become strongly associated with a professional or occupational group. These distinctive roles and values that shape the professional identity are largely adopted through the socialisation process and may become an integral part of how an individual construes their professional identity (Beattie, 1995). For example, the notion of 'caring' is historically and culturally associated with nursing and may be demonstrated by specific, key, 'caring type' roles. Furthermore, these values and roles may become so entrenched by cultural and historical expectations that their actions become 'sedimented' (Merleau Ponty, 1962; Butt, 2004). That is to say, the practitioner becomes so 'fixed' in their beliefs and roles that it is difficult for them to explore other alternative ways of working.

From our earlier examination, it is logical to assume that collaborative working would radically change the practitioners' culturally embedded roles, and in turn challenge the practitioners' constructs of 'what it is to be a nurse' or 'what it is to be a social worker'. This may then impact upon how practitioners relate to other professionals, their patients and the public. For some individuals and occupational groups this may mean holistic changes to their interpretations and meanings of their professional position, how they

construct their identity, and the meanings they assign to their roles. For instance, in terms of inter-professional working earlier research suggested that collaboration for some groups has meant compromising their professional beliefs for the goals of the joint working group (Higgins, et al. 1994). In this example it is quite possible that collaborative working may be construed as threatening and therefore practitioners may withdraw further into rigidly defined occupational boundaries (Biggs,1987). Whereas for others, collaboration means an opportunity for extending their work roles and reconstructing their identities in perhaps more satisfying ways than before (Fournier, 2000, Gelman, White, Carlson and Norman, 2000).

## **Conclusion**

In the first half of this chapter I have provided an overview of the term 'collaboration' and how the underlying concepts may be incompatible with a highly structured organisation and rigid ways of working, as may be found in the NHS and DHSS. At an operational level, the notion of collaboration encourages practitioners to focus upon the issues of professional identity and the relationships that shape occupational boundaries. However, in spite of the growing interest in collaborative working, there is little attention to the impact of collaborative ideology and ways of working upon the meanings that individuals assign to their professional identities and roles. Much of the literature is devoted to underlying structural mechanisms of inter-group behaviour or to cognitive theories that neglect the historical and culture relationships. Therefore, I argued for a constructivist phenomenological perspective that aims to explore the ways that professionals construe their identity within the changing context of collaborative

working. From this perspective professional identity is viewed as constructed through relationships and interactions between people, taking into account our individuality (personhood), as well as our contextual constraints. In this way the theory can account for the successes as well as the conflicts of collaboration within the caring professions. Since we are linked with our past history and culture, socialisation and professionalisation plays an influential role in our interactions and anticipations. Therefore, to understand the complexities of the relationships between the caring professions the next chapter will explore the history and development of district nursing and social work.

## Glossary

**Inter-professional collaboration:** Refers to 'relations between different professional groups, these may include medicine, nursing, and social work. Each one will have a distinctive culture which depends, on established professional bodies, training and an accrediting organisation' (Biggs, 1997).

**Multidisciplinary working:** Largely refers to teams. I have utilised this term to mean members from different disciplines from the same professional group, for example, health visitors and district nurses; whereas multi professional working refers to members of a team from different professional groups.

,

**Professional/practitioner:** I have utilised the terms 'professional' and 'practitioner' interchangeably throughout this thesis. This is defined as a person who has undergone specific professional training and is accredited by a recognised training body (organisation) in order to perform an aspect of client care. For example, a district nurse or a social care worker.

## **Chapter 3.**

### **Professionals, professionalism and the development of the care professions.**

#### **Introduction**

In the previous chapter I argued for a constructivist phenomenological approach towards the notion of profession identity, whereby identity is a negotiated and interactive process. Also, I suggested how ways of working and thinking may become 'sedimented' and fixed as a result of embedded historical and cultural values (Merleau Ponty, 1999, Butt, 1998). Therefore examining the historical development of nursing and social care work towards becoming a profession should give us an insight into the 'sedimented' aspects of their professional identity. However before I proceed it is useful to clarify some of the meanings surrounding the terms 'profession' and 'professionalism'.

#### **Professions and professionalism**

It is perhaps a 'common view' that professions do differ from conventional jobs and many people could list a few occupations that are regarded as a profession, for example medicine and law. However, there is little consensus between authors in defining a 'professional', and often the term is confused with professionalism. In laymen's terms professionalism is the ability to 'do a good job' or perform a task in an expert manner. For a health or social care practitioner it is also used to describe a moral obligation or a desirable way of working that is perceived as being in the best interests of customers or patients (Abbott and Meerabeau, 1998, Evetts, 1999). Often this is guided by an organisation's standards and codes of practice.

To define a profession is more complex and there are as many definitions as there are approaches to the topic. Early attempts to develop criteria for defining a profession have been largely based on a trait or functional approach. Trait approaches have emphasised the attributes of a profession in terms of altruistic ideals and the 'worthiness' of the occupation. Likewise the functional approaches have focused upon the specific services professionals provide that other people cannot provide for themselves (Friedson, 1983, MacDonald, 1995).

From a trait or a functional approach, the key characteristic to a professional status is the claim to a specific body of knowledge of higher learning. Here a professional is often referred to as

*'a person who by virtue of long training is qualified to perform specialised activities autonomously'* (Scott, 1969, p.82).

The underpinning assumption is that specific work is so specialised that it cannot be routinised into a set of rules or procedures, and is therefore inaccessible to those lacking the required training (Freidson, 2001). Hence, earlier commentators have argued that occupations such as teaching, nursing and social work are semi professional (Toren, 1969), because their training is shorter and they do not lay claim to a distinct body of knowledge.

In contrast, symbolic interactionists contend that the criteria defining a professional group are not stable or fixed characteristics, but that profession is a label that is largely socially constructed (Friedson, 1983, Larsen, 1977). Furthermore, it is contested that often the

pursuit for professionalism is not the desire for excellence or altruistic goals but more about attaining a desired social status and occupational monopoly. Therefore the label 'profession' represents a striving for power autonomy, authority, (Friedson, 1983, MacDonald, 1995, Witz, 1995), and for some practitioners it is thought to be incompatible with their occupational values and practice (Findlay, 2000).

Similar to the interactionist approach, my constructivist phenomenological position construes professional identity as an interactive process that is negotiated (Butt, 1996). However, rather than a focus upon the structures and social forces that may oppress the individual, the emphasis here is upon the meanings that professionals may assign to their identity and roles, and how this may influence their relationships with their social world. As I have explained earlier, practitioners are not always free to construct their own identity in any form they choose, but are to an extent tied to their past and to the cultural values that have become associated with their occupation. Perhaps tied to such an extent, that ways of working and anticipating become sedimented. Previous literature argues that there are values and expectations that are historically embedded and implicitly transmitted through professional socialisation (Dombeck, 1997). It follows then these are anticipated and expressed in their interactions with colleagues from their own and other professions, and with the general public. Since the historical context may account for some of the ways professionals anticipate their roles, I will now provide a 'potted' social historic background surrounding the emergence of the care professions. Earlier authors often refer to this lengthy process as 'professionalisation' (Larsen, 1977, MacDonald, 1995).

I might add that the social history of social work is less “tilled” than the field of nursing, and the historic recorded contributions of district nursing are relatively neglected and not easily located (Dingwall, Rafferty and Webster, 1988). Therefore, I have largely focused on the key events that were considered to have had an influential and enduring effect upon the professional development and relationships of district nurses and social care workers. Because the field of social care is so broad and complex, I have concentrated upon the development of qualified social workers rather than general social care staff. This will not deviate from the overall aims of the thesis, but will help to give an insight into the ethos that has underpinned social work as a whole and the changes that have led to the development of social care work.

### **Early social history of nursing and social care**

It is apparent from early records that nursing has a longer history than social work and that the art of caring for and nurturing the sick has been an essential aspect of sustaining life since the beginning of civilisation (Dolan, Fitzpatrick and Herma, 1983). The first nurses may be traced to the early assistants of the high priest or medicine men (Achterberg, 1990), and the first organised visiting of the sick recorded in Western societies began in medieval times with the ‘deaconess’ and ‘matrons’. Often these matrons were people of ‘noble’ birth who channelled their wealth and influence into founding hospitals and convents. Their duties probably consisted of bathing patients, dressing wounds, giving food, and providing physical and spiritual comfort to all patients; especially for the dying (Dolan et al. 1983). Often they were performed out of

the conviction that such 'acts of mercy' were good for the soul and secured them a place in heaven (Achterberg, 1990).

Nursing before the 1800s was 'not an identifiable and self-conscious occupation' (Dingwall, et al. 1988, p.4). Nursing care was provided in the patient's home by married women, who had gained their skills through the 'bringing up' of their own families. Their role and responsibilities were regarded as akin to domestic work and included laying out the dead, delivering babies and 'watching the sick' (Abel- Smith 1979, White, 1978). The wealthy families employed nurses in their own homes, either on a resident or a non-resident basis. Here the nurse was accepted and respected as a person of some knowledge.

In contrast, social work may be regarded as a relatively 'new' occupation created by Western industrial societies (Jordan, 1997). Before formalised social care, vulnerable groups, such as orphans, widows and the elderly were supported within a family or the tribe. Through the Middle Ages in Western Christian societies, the care of the poor and afflicted tended to rest upon the monastic orders (Brandon, 1998).

Between the 1600 and 1800s social care was based upon the Elizabethan poor laws and therefore the poor were the responsibility of 'parishes', supervised by the board of Guardians – an early type of local government. Those 'poor' or infirm who did not have family support were provided with periodic financial relief and care in their own homes

or in local poorhouses (White, 1978). The quality and equity of both nursing and social care across the country was patchy and varied dramatically from parish to parish.

By the beginning of the nineteenth century the Industrial Revolution was well under way, bringing with it momentous and rapid changes in the social scene as well as in attitudes towards health and social care. Notably, the new-found technology brought high rural unemployment and sudden population shifts as people migrated to the new industrial towns, resulting in overcrowding, poverty and sickness. The review of the contemporary literature paints a grim picture of the treatment of the sick and vulnerable. In an attempt to contain the problems of unemployment, vagrancy and old age, the poor laws were revised whereby the destitute, the 'poor sick' and insane were separated from families and isolated from general society and placed in bleak workhouses. (Abel-Smith, 1979)

The general belief amongst the upper classes and landlords was that *'poverty was caused by improvidence which was alleviated by discipline'* (White, 1978, p.10). Therefore to deter the lazy, self-help was encouraged, relief was kept to a minimum and state assistance was provided through voluntary organisations. The conditions within the workhouses were recorded as appalling, with poor sanitation and little food. The other able-bodied paupers looked after the sick in the poor houses. Furthermore, drunkenness was rife amongst the staff and the inmates (Reed and Procter, 1993).

Alongside the increasing number of workhouses there was also an increase in the number of voluntary hospitals. These charitable hospitals were maintained by subscriptions and often were selective in their choice of patients. The facilities were often

poor and unsanitary, and knowledge of disease was rudimentary. The nurses had a paucity of equipment, and there was little incentive for them to perform their duties.

While industry and the economy flourished for the entrepreneurs, the population and unemployment continued to rise. Stories of the increasing depths of misery and deprivation amongst the poor and the sick began to reach the ears of a few aristocrats and the emerging middle class. The participation in charitable works, such as nursing and social care would ease the conscience of some of the wealthy, as well as provide a suitable outlet for the 'energies' of high and middle class daughters (Abel-Smith, 1979).

### **Development of nursing**

Amidst the social and economic changes there was a growth in voluntary and charitable hospitals. In spite of the conditions described earlier, it was here that the doctors learnt their art, gained their prestige by awarding themselves 'honorary consultancies' and developed their private practices. The doctors performed the majority of technical skills such as administering potions and bandaging (White, 1978).

In contrast, the general position towards nursing the sick was that it was a menial task akin to housework, which therefore did not require any training. Consequently, nurses were drawn from the domestic servant classes who were regarded as able to face the confusion and stench of the wards, motivated by a tot of gin (Abel-Smith, 1979). The sisters and matrons were drawn from a higher social status. They supervised the nursemaids, administered the medicines and managed the wards. Overall, the social status of

nursing early in the nineteenth century was low and their conditions of service were variable and held little reward (White, 1978).

The development of medicine and the conditions of the sick and injured during the Crimean War brought attention to the need for skilled and knowledgeable nurses (Reed and Procter, 1993). Although there were many other key figures that founded modern day nursing, none was more influential and popular than Florence Nightingale. She pressed for formalised nurse training and based upon her military experience, a training school for nurses was established in 1860.

Trainees formed a varied group, mainly comprise of educated middle class ladies who paid their way, and servant girl probationers. Training was brief, gruelling, and reflected the Victorian attitudes of the day, such as military discipline, obedience, and high religious morals. The trainees were expected to 'live in' and devote themselves to the work before family and husband. Perseverance and loyalty to the group were encouraged, in spite of over-work, long hours and poor payment. This sense of 'struggle on' rather than break a code of honour is perhaps evident in some aspects of contemporary nursing culture (Abel-Smith, 1979).

The demand for nurses was great at the time, given the increase in the number of hospitals and the development of medical techniques. However, in spite of the upsurge of nurse training, standards and practice varied widely across the country (Baly, Robottom and Clark, 1987). To resolve this situation, and perhaps driven by the need for status and

occupational monopoly (Abbott and Meerabeau, 1998), a group of nurses banded together to fight for recognition and registration. In spite of Florence Nightingale's resistance to this Act (Jolley, 1989) their goal was finally achieved by the introduction of a statutory register through an Act of Parliament in 1919. The battle of receiving official recognition and professional status may have been won, however, the internal squabbles over qualifications and standards had only just begun. While hospital nursing was receiving recognition and popular support, specialist areas of nursing such as district nursing received little attention.

### **District nursing**

Although nursing began within the community, the benefits and the skills of a district nurse were not acknowledged or recognised at this time. With the emergence of the scientific age and the development of medical techniques, hospitals had become popular amongst the upper and middle classes. They were now places where patients may be cured, rather than places where the sick were stored. Nevertheless, the role of district nurse was linked particularly with social welfare and improving the conditions of the poor in the community. Religious organisations and associations were beginning to respond to the plight of the poor by providing 'visitors' to minister to the spiritual and physical needs of poor communities. One such organisation was the Bible and Domestic mission in London supervised by Mrs Ranyard (Dolan et al. 1983). Other community projects followed, initiated by successful businessmen, notably Mr Rathbone, a ship builder of Liverpool (Dingwall, Rafferty and Webster, 1988). From personal experience Mr Rathbone had observed the benefits of district nursing (with a home-nurse caring for

his wife), and in 1859 paid a home-nurse to provide nursing care for the poor and to teach them ways to improve their standards of living. In 1862, with the advice of Florence Nightingale, he organised a training school for nurses in Liverpool, which also provided training for community nurses (Dolan et al. 1983).

Following on from these various projects the government began to realise that it was essential for the community to employ district nurses with a sanitary and nursing care role (Baly et al. 1987). It was anticipated that to fulfil this role a high calibre of woman was required, who could provide treatment in the absence of the doctor. Therefore some form of recognised training, and formalised standards of care, were thought to be a necessity. In response to government reviews the Metropolitan and National Nursing Association for Providing Trained Nurses for The Sick Poor was created in 1875; under the supervision of a Ms Lees (Dolan et al. 1983). Later in 1889, another project was sponsored and chartered by Queen Victoria, the Queen Victoria Jubilee Institute for Nurses. Training at the institute was lengthy and solely directed towards teaching district nurses. Those who had undertaken this training programme were entitled to wear the distinctive uniform and badge, and bore the prestigious name, 'Queen's Nurse'. However, the institute's high entrance requirements and expense resulted in few nurses being trained (Dingwall et al. 1988).

During the early twentieth century district nurse practice varied widely across England; nursing associations were fragmented and training schools were few. Often the district nurse was an all-purpose community worker –'handywoman' dealing with all ages, and

by the profession's own admission was thought to be performing too many non-nursing tasks (Baly et al. 1989). Leading up to the Registration Act it was still difficult to determine the standards and define who was qualified to be a district nurse. When state registration became a reality in 1919, registering with the General Nursing Council became a prerequisite for starting district nurses training. The Queen's Institute was given the responsibility to provide the district nurse training programme and later, in 1928, the school changed its title to the 'Queen's Institute of District Nursing'.

However, the cost of training and employing qualified district nurses continued to be a problem in some districts for many years. Unlike some specialist branches of nursing such as midwifery and health visiting, district nursing was not accepted as a public obligation. A very small proportion of costs came from public funds, and this only slightly improved following the National Insurance Act in 1911. Also, the qualified Queen's Nurses were reluctant to work in the rural areas because the poor pay did not compensate for the *'social deprivations and the hostility of the local general practitioners who felt threatened by these new professionals'* (Dingwall et al. 1988 p.182).

The interwar years for district nursing appear comparatively quiet, and perhaps little changed. Also, little is documented concerning the district nurses' contribution to the war effort (1939-1945), and in comparison with health visiting they appear virtually invisible. However, literature informs us that following the National Service Act (1948), many nurses working in the district remained untrained and continued to be all-purpose workers. This situation continued until 1951, whereupon a panel of assessors for district

nurse training was assembled, and introduced a reduction in district nurse training from six months to four months (Baly, Robottom and Clark, 1987). What was perhaps meant as a temporary measure to meet an ever-increasing demand for more trained district nurses, led to the Queens' Institute surrendering the training of district nurses in 1968.

At the time district nurses felt the loss of prestige as 'Queen's Nurses', with their distinctive training and uniform. Furthermore, they had lost an independent professional body, and therefore viewed themselves as the '*Cinderella of the primary care team*' (Baly, Robottom, and Clark 1987, p.338). This was perhaps compounded by plans for restructuring the nursing profession in 1972, following the Briggs Report. Some authors argued that the proposed reorganisation of the nursing profession favoured hospital interests (Dingwall et al. 1988). It took many years for district nurses to feel they had regained their professional status. In 1981 a district nurse committee was formed, and under the supervision of the central council and national boards, a new training programme was established. From then on only those who had undergone the mandatory training could use the title district nurse.

### **Moving forward**

Historically, district nursing has been overshadowed by the developments of hospital services, as until recently the government has directed its resources towards hospital care rather than the community. It is therefore understandable if there is a sense that district nurses remain unrecognised and undervalued as a 'Cinderella' service. However, since the 1980's and the recent drive of modernising health services (DOH 1999), the

government has seen the benefit of changing the NHS from a sickness to a health-orientated service. Therefore it is hoped that the benefits of district nursing, as first recognised by Rathbone, will mean that primary care may take its rightful place- centre stage.

Even so, contemporary district nursing has come along way from general all-purpose community work. Since the 1990's many activities previously associated with health care now fall within the remit of social care; for example, simple dressings and personal hygiene. The main emphasis of district nurse has changed from offering interventionist care towards leading nurse teams, coordinating, teaching, facilitating and auditing care. Furthermore, the increase of 'hospital at home schemes' has meant more complex and technical nursing occurs within the home (Kelly, Mabbett and Thome, 1998), and therefore, there is a need for 'skill mix' in district nurse teams. For some district nurses this may be a welcome challenge as nursing becomes more highly skilled and takes on responsibilities and decisions that were once made only by the medical profession. However, there are others who may argue that these changes distance them from the patient, and from performing their specific caring roles, which they found rewarding, and which were historically central to their professional identity.

### **Image and role**

From the literature there appear to be two enduring images of a nurse that resonate from ancient cultures to the present day. The first is that of a 'well-prepared' woman who was recognised as one of authority and importance in the maintenance of health. The second

was of a maidservant or slave, dependent upon a physician (or priest), who 'assumed a subservient role' (Dolan et al. 1988, p.8).

The two images almost invariably relate to how the public view the task of nursing the sick. For example, in the nineteenth century nursing was viewed as unskilled housework (Achterberg, 1990). The value of nursing was not really recognised until the development of medicine, or during times of crisis, as in states of war. Therefore it is understandable that since the late nineteenth century nurses have striven to distance themselves from this servant image, and been keen to demonstrate their skills and push for the professionalisation of their occupation.

A review of nursing literature also suggests that the setting and the history in which district nurses have emerged may well account for some of the features of the profession; for example, the high proportion of women (Pizurki, Alfonsa, Butler and Ewart, 1987) the tendency to withdraw to the solidarity of the uniformed group, the sense of discipline, vocation and commitment to the job- characteristics which still pervade in nursing.

### **Development of social work**

In contrast to nursing, the history of social work is relatively short and is commonly traced back to the early nineteenth century. Social work developed in response to social problems that emerged from the rapid industrialisation and urbanisation in the nineteenth century (Jordan, 1997). The harshness of the amended Poor Laws (Poor Law Amendment Act in 1834) did not reduce the poverty and deprivation, and the plight of the poor was

recognised by a number of reformers. Hence, various charitable groups grew and began to undertake 'social work'. However the fear that '*indiscriminate giving*' may lead to the '*feckless and lazy receiving help*' (Parrott, 1999, p.22), paved the way to the formation of the Charity Organisation Society (COS) in 1869. The aims of this society were to organise differing charitable groups, and to provide a systematic assessment of people's circumstances, so they would be sure that only the deserving would receive benefit.

The techniques in moral surveillance were to form the basis of a general approach to social work. Applicants were interviewed and their backgrounds were assessed and recorded in case notes or files. Case notes were to be recorded 'scientifically' using a rational, detached approach. To equip social workers in these investigative techniques COS developed a training course and established the school of sociology in 1902 (Parrott, 1999). The training was highly academic and included social theory, administration of welfare, social philosophy, and social and economic history.

However, the practice of social care varied and the disciplines within social work differed wherever the need arose. By the end of the nineteenth century social work could be classified into different fields of work to deal with the 'social problems' of poverty, sickness and old age. Examples included children's visitors, court missionaries attached to law courts, charity officers who were employed by the workhouse unions, and hospital alimoners (Horner, 2003). Most of the social workers were employed by voluntary welfare agencies as moral welfare workers. Gradually, there was recognition by the government of the need to take responsibility for aspects of social welfare and so policies

began to move away from the principles of COS. By 1929 the Poor Law was abolished and responsibilities of welfare were transferred to the local authorities.

During the interwar years, social work moved away from social reform and began to broaden its knowledge and expertise by adopting the science of psychology and psychoanalytical techniques from the USA. This was a useful move for the developing profession as it meant they could be seen to be rehabilitating people back into society by supporting the services of medicine, psychiatry and criminology.

World events and changes in government attitudes towards public services favoured the development and expansion of social work in the 1940s and 1950s. Significant events included the Beveridge Report of 1942. This proposed that the state should take a leading role in providing services for all, not just the disadvantaged, and paved the way for the National Insurance scheme in 1946 and the establishment of the National Health Service in 1948. Also, the Second World War had disrupted family and community relationships, and with the subsequent high levels of unemployment there was a perceived need for social workers, particularly in the area of medicine and children's work.

However, social work was not without its problems in the early days; scandals, and disastrous outcomes from poor child placements came to the attention of the public. This led to an examination of social work practice and the call for more 'trained' workers (Parrott, 1999). The broad range of social work meant that it was fragmented, with no unifying occupational body monitoring training and standards of care. At the time social

work training was often through the supporting charitable bodies or differing agencies, and little changed until the Seebohm Report (1968).

The aim of the Seebohm Report (1968) was to provide an integrated, community based service and to explore the 'root causes' of social problems. Through the recommendations of the Report, each local authority would have a social service that was organised into departments. Also, generic training for social workers was to be established (Horner, 2003) - overseen by the Central Council for Education and Training of Social Work (CCETSW). The CCETSW was finally established in 1972 to regulate and standardise social work training in Britain; out of which two qualifications for social work emerged, the Certificate of Qualification in Social Work (CQSW) in 1972, and in 1976 the Certificate in Social Service (CSS) for those working in residential and day care. These were later merged in 1989 to become the Diploma in Social Work.

From the post-war years until 1976, social work appeared to be at its height, the future for social work seemed promising in terms of what it could become and what it could provide for the community. Welfare services expanded as a result of increased public expenditure. However according to earlier authors (Parrott, 1999) this euphoria was to be short lived.

By the mid 1970s the reorganisation of the service uncovered shortfalls within the service, Social Services were then subject to a series of external enquires and criticisms which had an undermining effect upon its practitioners (Horner 2003). With the election

of the Conservative party in 1979 and the promise of reduced public expenditure, came the return of the Poor Law's ideals of self help and individualism, and the introduction of markets to manage health and social care (Hudson, 2000). The new administration called upon the Barclay committee to review the roles and purposes of social workers. The recommendations of the Barclay report (1982) were thought to compromise some of the proposals of the earlier Seebohm report (Parrott, 1999). Nevertheless, the review argued for a 'less ambitious' social service, a closer examination of the demands made upon the service, a closer involvement with private and voluntary sectors, the development of community social work and the development of social workers as 'enablers'.

Changes in the way services were delivered were further reinforced by the Griffiths Report in 1988, and *Caring for People*, a White Paper on Community Care in 1989. These documents encouraged the return of long-stay patients to the community and advocated an inter-professional approach to the complex needs of these individuals within the community. These proposals were finally presented as the NHS and Community Care Act (DOH, 1990), and were implemented in 1993 (Horner 2003). The NHS and Community Care Act proposed an inter-dependency between health and social services and a gradual devolvement of aspects of care from health to social services. The thrust towards managerialism initiated by the Thatcher government was further encouraged by the New Labour administration (1997 to present day), with the focus upon partnerships and consumer-orientated services. Hence, social and health services began to be organised and managed like businesses. This led to a change in the roles of social workers. No longer would they support and provide care as caseworkers, but they

would become assessors, organizers, and purchasers of care packages. For instance, trained practitioners in the area of adult care would be known as social care assessors. Aspects of social care, such as washing, would now be contracted to other private and voluntary agencies not requiring the high level of training of social workers (Jordan, 1999).

### **Role and image**

The role of the social worker is perhaps vague to many; most people can describe a nurse or a doctor or a teacher, yet have difficulty describing a social worker. This is perhaps attributable to the social workers' field of practice on the periphery of society. For example, a proportion of social workers will be working amongst a small proportion of very elderly people, children who are officially protected or monitored by the state, those with physical disabilities, and the mentally ill people living in the community (Horner, 2000). Therefore much of their work may go unrecognised by other professionals and the wider public. Furthermore, it may be argued that aspects of their work are overshadowed by the media attention over public enquiries. The area of children's work appears to be particularly newsworthy and of public interest. In spite of the involvement of other professionals, social work's contribution to a disaster is brought to public attention via the media. Usually this is over the issues of either failing to intervene in cases of child abuse, as in the cases of Kimberley Carlisle (DOH, 1987) and Victoria Climbié (Lord Laming Report, 2002), or unnecessary, over-zealous intervention. For example, ambiguous medical and social evidence of personal and satanic abuse led to the removal of children from families in Cleveland and the Orkneys by local authorities (DHSS, 1991).

However, perhaps the failure of social work's positive contribution to find widespread public recognition, lies in the duality and the contradictory nature of social work. For some practitioners, the different aspects of their role were viewed as ambiguous, creating conflicting interests between the client and their statutory obligations. Also, the beliefs underpinning the social work methods were questioned. On the one hand they appear as caring advocates of the poor and vulnerable. On the other hand their obligations were forged by the state, restraining them from deep involvement with clients (Toren, 1969, Jordan, 1997), and prevented them from being permitted to work as an independent professional group. It is this ambiguity that has posed difficulties for some practitioners, who regard their position as little more than professional bureaucrats (Lymbery, 2000) or resource managers (Parsloe, 2001).

From within the discipline, social work has always regarded itself as a moral activity. In the early years of the Twentieth Century imposing Victorian standards and morals upon the client; nowadays focusing on showing respect for persons, advocating diversity, enabling and empowering individuals, and combating the processes that lead to discrimination. In this way it is argued by Horner (2003) that social work stands separate from other occupations.

*'It is the tradition of being difficult and awkward, challenging assumptions and 'givens' in the social order that must represent social work's distinctiveness.'*

(p. 128)

Returning to the notion of professionalism, the acceptance of social work as a profession creates mixed viewpoints amongst its own practitioners and writers. Like the nursing occupation, social work underwent roller coaster experiences of heated debates over issues of professionalism, for example specialism versus genericism. Then came the disagreements over standards and accreditation, training versus graduate education (Parsloe, 2001), and arguments over their roles and purposes. One recurring theme was the concern over how social work could establish itself as an autonomous profession. However, with the current focus upon empowerment and client centered services, the traditional concept of professionalism is considered by many practitioners to be exploitative towards both practitioners and carers (Jordan, 1997), and oppressive towards service users (Findlay, 2000).

#### **Moving towards inter-professional working and education.**

From the review of the literature it is reasonable to conclude that the historical and social development of the care professions may influence the practitioners' perception of how they construe their profession and their relationships with other practitioners. The relationship between doctors and nurses has been a long one: they have worked alongside one another, and have learnt to play 'the doctor and nurse game', at times collaborating, and other times opposing each other (Blane, 1993). In contrast, social workers and district nurses have largely developed independently from each other. Until recently, professional socialisation has taken place in separate training schools, with little or no direct contact with other disciplines. Therefore we should not have been surprised to learn of the difficulties encountered between these occupations in the early days of community care (see chapter 2).

To overcome misunderstanding and territorial boundaries, recent legislation and recommendations have proposed the need for multidisciplinary education, and the need to review the skills and practices across the professions associated with the NHS (Soothill, Mackaul, and Webb 1995, NHS plan 2000). Professional education is deemed to play an essential part here in explicitly transmitting skills and appropriate codes of behaviour towards the patients, as well as towards other professionals. Therefore by enabling professional students to learn more about one another and to share learning, it is thought that prejudice and negative stereotypes will be countered (Barr, 2000).

From a constructivist phenomenological position the weakness in this argument lies in the failure to recognise that individuals do not come to training as a blank page, ready to absorb the teaching programme. Many students come to training with their own personal constructs of what they believe nursing and social work to be, as a result of their previous encounters and cultural experiences (Kelly, 1955). Likewise, people do not merely learn by experience, but also will review their personal meanings and perspectives as they interact with others (Tooth, 1996). Therefore, learning to work as part of an inter-professional team is not merely a cognitive process, but is a 'construing in action', whereby professionals learn (pre-reflectively) to recognise and anticipate each other's intentions and meanings, through body stance, gestures and role performance.

## **Conclusion**

This chapter has explored the concept of professionalism, and particularly examined the development of district nursing and social work. Like other occupations, district nursing

and social work have sought to develop a distinctive knowledge and expertise, and have aspired towards gaining social recognition for their contributions to care. In many ways their rise to professionalism has been about job monopoly, uniqueness, and privilege, all of which demand defined specialised roles and knowledge. For some practitioners this perception of a profession appears incompatible with the notion of caring and collaborative working. Not surprisingly more recent authors (Finlay, 2000) are now re-examining the notion of 'profession', as the traditional concept not only inhibits collaborative working but also adversely affects their relationships with their clients.

Examining the history of the care professions, it may be seen that some distinctive features remain within the occupations today. For instance, nursing has remained a uniformed group and recognized by others as having high sense of commitment. Nevertheless, in some respects the development of district nursing and social work (in general) share a common historical background. Both services are predominantly female occupations (Achterberg, 1990, Witz, 1992) and have emerged out of household and voluntary community work, with their roots associated with religious orders. Unlike the relationships that have developed between nurses and doctors, the relationships between district nurses and social services do not have the same perceived power and status imbalances, nor the historic dependence (Blane, 1991). Perhaps then, it can be argued that district nursing and social work share a good common foundation on which to build effective inter-professional relationships (Tooth, 1996). However, at times the experiences between the professionals have been reported as problematic (Biggs, 1997), as outlined in the previous chapter. In order to resolve these difficulties, literature has

focused upon either organisational barriers or problems that may be inherent in the individual. To enhance our understanding I have argued for a contemporary approach to study that explores the meanings of identity as construed by the practitioners at operational level. The next chapter will expand upon the underpinning theoretical perspective and the methodology employed in the empirical studies.

## **Chapter 4.**

### **Epistemology and methodology**

#### **Introduction**

So far, we have explored the differing structural and organisational approaches to professional identities and collaborative working. I have argued how these theories do not account for the successes and the failures of collaborative working, nor acknowledge the active participation of the person within their social world. Therefore, I proposed a constructivist phenomenological approach to this project. To go a step further, this chapter aims to describe the theoretical and epistemological assumptions that underpin constructivist and phenomenological thought, and how these theories guide the methodology and methods selected. To simplify such a daunting task I have presented this chapter in two parts. The first section will be a discussion of the constructivist epistemology, and the methodology used to frame this project. The second section of this chapter will give the reader an overview of the steps taken to prepare for data collection and analysis, and the quality and ethical issues concerning qualitative research. Since I have utilised different sampling techniques and data collection tools in the different studies, these will be described fully in the following empirical chapters.

#### **How do we know what we know?**

Before I begin this research it is important that I consider the following questions, "How do we know what we know?" (Crotty, 1998), and, "What is my position on reality and truth?" In answer to these difficult questions I have adopted a constructivist epistemology which shares similar features to interpretive and constructionist philosophies.

Interpretive understanding originated in German thought - *verstehen* (understanding) as a reaction to the dominant positivist philosophy of the early twentieth century. Sociologists and historians such as Weber and Dilthey contended that social science sharply contrasted with physical science both in its approach and purpose of study. The natural sciences argue that there are discoverable, universal 'truths', and draw upon a 'realist' concept of knowledge (Guba, 1990). Therefore, it is possible to know and discover an independent external reality through stringent 'objective' methods (Lincoln and Guba 2000, Crabtree and Miller, 1999).

In contrast, the interpretive approach to understanding does not attempt to identify causal explanations of social phenomena. Instead, people's actions are construed as 'intentional' and therefore the investigator seeks to understand meanings that lie behind human action. Under this umbrella of thought there are varying philosophical approaches to how investigators may gain access to these meanings and how these meanings are represented. One way of understanding meaning is to 'empathetically' identify with the person (Dilthey, 1958 cited in Schwandt, 2003). The general idea is to transcend one's own cultural context, in order to reproduce the meaning of the actor (Husserl, 1930). This may suggest that the researcher can claim some degree of objectivity and come to know and interpret the meanings of others through correctly employed methods. However, social constructionist philosophies argue that knowledge about human experience cannot be gained directly and objectively (Crotty, 1998), because the inquirer cannot entirely step outside their personal and cultural values, and political prejudices (Polkinhorne, 1992).

For those unfamiliar with social constructionism, this is an encompassing term to describe a body of theories that generally asserts that the locus of knowledge and interpretation is relational, that is in many ways we construct our knowledge through social interaction (Mead, 1934, Gergen, 1997, Mackay 1997). Also, our knowledge is culturally and historically specific. Within this body of thought, there are varying views concerning the role of the individual (cognitive) and the social processes in human action, and how we understand the relationship between knowledge and reality (Chiari and Nuzzo 1996). For this project I have adopted the term constructivist to acknowledge a more proactive participation of the individual in constructing their reality (Warren, 1998, Botella, 2000) than with discursive psychology, where the concept of the person is viewed as a product of discourses or social structures (Shotter, 1993). Furthermore, I argue (along with other authors) that in spite of the individual differences in cognitive processes, interpretations and experiences, sense making and cognition are not completely divergent (Polkinghorn, 1992). There are commonalities between people in expression, language and categorisations of events. Therefore, by sharing the same world as others, it is conceivable to come to understand (although in a limited way) the expressions actions and intentions of others, and in this way represent another sense of knowing (Kelly, 1955) As Spinelli (1989) points out reality then can be 'both unknown and knowable to us' (p.2). To remain consistent with this middle 'relativity' ground between idealism (subjectivism) and realism, I will draw upon the theories of personal construct psychology (PCP) and existential phenomenology.

## **Personal construct psychology (PCP)**

Fundamental to PCP is the notion of constructive alternativism, where knowledge and reality is open to alternative constructions and differing realities. Central to the theory is the concept of personal constructs, these are defined as channels or networks through which an individual organises, understands and anticipates events (Kelly, 1963). Kelly makes this point in his fundamental postulate,

*'a person's processes are psychologically channelised by the ways in which he (or she) anticipates events.'* (p.46)

Therefore people make sense of what is happening by bringing to events their values and interpretations gained from their previous experiences. Also, Kelly argued that the way we interpret and develop our constructs are individual. Nevertheless, people who share the same culture or social world, in many ways may share similar ways of construing. For instance, having been a nurse I may use similar constructs to district nurses to describe nursing care. But I may place an emphasis on different aspects of nursing care that relate to my personal experiences. Therefore as a researcher, I am aware that I may bring to the research event, personal and cultural assumptions and anticipations, which may lead me to construe the participants in a particular way. However, existential phenomenology does provide tools that help us to overcome some of these dilemmas.

## **Phenomenology**

Complimentary to PCP is the philosophy derived from existential phenomenology (Butt, 2004b). Here, phenomenology's orientation to people in relation to the world and others (intentionality and intersubjectivity) holds particular appeal. Generally phenomenology seeks to enquire how we experience the world, as it appears to us -rather than explaining

the world. One form of phenomenology (Transcendental) aims to understand the nature of being, by uncovering the internal meanings or “essence” of a person’s experience, through separating the essence (true nature) from the presuppositions of culture. Husserl (1931/1980) described these ‘taken for granted’ cultural assumptions as our ‘*natural attitude*’ (Spurling, 1977, Becker, 1997) and developed the concept of epoché. In practice it is argued that it is possible to suspend cultural assumptions by ‘bracketing’ one’s own constructions of meaning around the phenomena to access the participant’s intentionality and meaning. However, I support contemporary existential thought that the person’s experiences cannot be broken down into abstractions and essences (Spurling, 1977). Furthermore, because we are ‘thrown’ into a social world and inseparable from it, the element of neutrality and objectivity required within this process is unachievable (Butt, 2004). Although I may not be able to stand outside my situation, through the employment of bracketing I may be encouraged to revisit the experience in a different way and gain new insights into a phenomenon from a participant perspective (Crotty, 1988, Moustakas, 1994). I will explore these concepts further later in the chapter.

Moving on from Husserl to the later work of Heidegger and Merleau Ponty, the focus has changed from revealing essences and structures, to relationship of being within the life world (Spurling 1977, Valle, King and Halling, 1989). Merleau Ponty advanced the notions of existences and experiences by acknowledging that consciousness does not create the world, nor is it created by the world. For Merleau Ponty meaning is created in the dialectic and is described as the back and forth relationships between self and the other. It is here that the similarities with PCP are quite striking (Holland, 1970).

Furthermore, Merleau Ponty (1962) argued that within these interactions we recognise the anticipations and intentions of the other through speech, bodily expressions and posture. Often these interactions are 'pre-reflective', that is to say, they are a part of our automatic functioning and are not brought to our awareness unless we are caused to reflect upon them after the event (Kelly, 1955, Butt, 1998). Even then such embodied actions may be without word handles or symbols. For instance, when I asked my (11 year old) daughter how she remembers to play particular pieces on the piano, she struggled to answer and finally said 'my fingers remember'. She could not consciously memorise or describe how each finger played a particular note but she remembered when she started to play. In this way it can be said that people construe in action. Thus, it may be difficult for care professionals to describe their everyday professional interactions outside the context of work, and for that reason they may find it difficult to describe what it means for them to be a nurse or a social worker. Therefore, in the design of the research project it is essential to consider creative ways in accessing meanings and intentions.

### **Methodology**

To reiterate, my intention towards this project is to explore meanings of care professionals, rather than measure aspects of their reality. Therefore the research design is not a linear process as one may find in traditional positivistic research. In contrast, a constructivist phenomenological approach can be described figuratively as interlinking cycles between the theoretical approach, the way data is collected, analysed, and presented (Addison, 1999). The way one begins, plans and takes part in this process has been compared with organising and preparing for a major 'dance' (Miller and Crabtree,

1999), where the pertinent questions are ‘what form shall the event take? What music shall be played? Who shall I invite?’ (p.130). In response to some of these questions, I take the view that one of the ways to access beliefs and experiences is through individual (and group) semi-structured interviews (Smith, Jarman and Osbourne, 1999, Kvale, 1996).

One of the problems of interviews is that language is not transparent, and does not always reflect peoples views, thoughts and feelings (Burr, 2003): there are times when people do not always say what they mean and there are times when people are inconsistent in what they say. Also, words (whether spoken or written) may have different meanings according to the context and may change over time. Returning to my ‘musical’ analogy, even though I am not a musician, through listening to my daughter practicing piano pieces, I have come to recognise the rhythm and patterns of the tunes she plays. Through her personal reactions to her playing and comparing with how she has played before, I have come to know the notes she intended to play and the notes she regards as a mistake. Likewise, through listening to care professionals, utilising different interview instruments and the phenomenological approach to treating the data I will begin to grasp aspects of the lived experiences of care professionals (Van Manen, 1992). As I have utilised different interview methods for the different studies I have explained the sampling procedures and data collection tools fully in the empirical sections following this chapter. At this point I will give an overview of the project design.

This project adopted a multi-method approach of three discrete studies, which aims to create a comprehensive account of the ways care practitioners from different organisational cultures negotiate their identity and relationships in joint working practice. I described earlier in the literature review (Chapter 3) how the socialisation period plays an influential role in the shaping and strengthening of values and meanings of qualified professionals. Therefore, I felt it was important that the first empirical work would consist of a preliminary study of final year students educated at a university local to the area of the following two studies. It was likely that the local university provided the education for many of the care professionals within the area of study and the curricula at the time were similar to many universities across the country. I anticipated that through exploring how training prepared care professionals for their occupational roles and joint working practice, I would gain a comprehensive insight into the different cultural backgrounds of these two professions.

My overall aim was to explore the ways district nurses and social care workers construe their identity within the changing context of collaborative working. I have mentioned in chapter two how inter-professional working may impact upon the identity and roles of care practitioners. Therefore, the second study would explore services that were about to undergo developments, which involved inter-professional joint working between district nurses and social care staff. By collaborating with a service in its early stages of transition I anticipated that I would gain an insight into how staff groups anticipate and adjust to role changes as they were happening. The chosen district, which provides the context for the second and third study, was experiencing such change. As part of the

government's modernisation programme district nurse and social care managers were planning services that required close inter-professional working between district nurses and social care workers. Also, I concluded that the most appropriate way to gain the breadth and diversity of views, as well as explore how staff groups negotiate their identity was to utilise focus groups.

The aim of the final study was to provide a detailed descriptive account of how care practitioners negotiate their identity and relationships at an individual level during a 'typical' day-to day joint working event. It was thought utilising the Hargreaves interpersonal technique (1979) and the Salmon Line (1984, 2003) would encourage practitioners to reflect and describe their relationships with other practitioners.

### **Preparing for data collection and analysis**

I will now discuss the techniques and methods to be used to address the research aim. Earlier in this chapter I mentioned the phenomenological methods of epoché and bracketing which are central to the philosophy of phenomenology. Often these terms are used interchangeably and perhaps are confused with the notion of reflexivity. Therefore it is important at this point to clarify these terms and describe how these methods were applied to this project. This will be followed by a description of the way data was recorded and analysed.

## **Epoché**

Epoché is derived from a Greek work, meaning to 'withhold judgement' (Moustakas, 1994). It is a phenomenological method advocated by Husserl. As I have mentioned earlier, we all lean to a natural attitude of presuppositions, which will probably influence the collection, analysis, and interpretation of data. This natural attitude is described as a 'taken for granted' common sense knowledge, which we have gained through the socialisation process and our cultural and historic experiences. For instance, many years ago I worked as a nurse, and therefore when interviewing district nurses it would be very easy for me to slip into the common assumptions and language that are shared by nurses. Consequently, I may fail to question the participants as deeply as I would if I had not been a nurse. The epoché is described as an attitude (or method) towards research that encourages researchers to revisit the phenomena in a new way, by approaching the event as if they were 'a stranger who does not share the natural attitude' (Butt 2004, p. 91). The researcher is able to approach the event with openness while at the same time maintaining a critical stance, through questioning the participant's accounts and meanings.

## **Bracketing**

The process of setting aside these biases and natural assumptions (natural attitude) is referred to as bracketing. Rather than a transcendental view of bracketing to discover essences, the aim of bracketing here is to encourage a questioning reflective attitude that 'promotes curiosity' and allows for new ways of seeing (LeVasseur, 2003). Kelly utilises

a similar approach in what is called the '*credulous attitude*' where the psychologist attempts to,

*describe accurately the highest levels of his (sic) subject's system at the lowest possible levels of abstraction in his own system* (p.174)

To do this, it is essential that my past nursing experiences and my personal opinions concerning the role of nurses and social workers be placed to one side. This is arguably an unachievable task, as there are perhaps cultural values that are stamped indelibly on my thinking and actions. However, attempting to bracket my natural attitude will bring an awareness of at least some of my potential biases, and hopefully lessening their impact upon this research (Spinelli, 1989).

•

To help me recognise my potential areas of bias I adopted a few strategies at different stages of the data collection and analytical process. First, during the design of the interview schedules I entered into a type of role-play, to help me consider questions a person may ask without a nursing or social work background. These questions were written into the interview schedule and served as useful reminders during the interview process. Second, at the beginning of each interview, I introduced myself as a university researcher, and consciously did not inform the participants of my nursing background. This helped me to distance my self from my previous knowledge and past. Also, by announcing my lack of knowledge to participants it was anticipated that they might give more detailed responses to my questions. Third, I found it useful to record my overall reactions about each interview and any particular incidents that occurred during the interview. These field notes served a dual purpose; first, I was able to reassess my

interview schedules and second, the notes helped me to reflect upon the impact I had upon the interview situation (see reflexivity below). Finally, throughout the course of this project I called upon the advice of supervisors and colleagues who would challenge my thinking and interpretations, and offer alternative ways of viewing the data.

### **Reflexivity**

From a constructivist phenomenological position, reflexivity is inseparable from the process of bracketing. Reflexivity is a technique commonly used in qualitative research to acknowledge the proactive participation of the inquirer in the research process. Moreover, reflexivity within the research project makes explicit the actions, deliberations and impressions of the researcher, and how their values and beliefs influence what they observe (Flick, 1999, Crabtree and Miller, 1999, Murphy et al 1998). Therefore, it is reasonable to assume a phenomenological researcher would engage in reflection, so as to become aware of their own values and beliefs before they can place them on one side (bracketed). This reflexive exercise takes place at different levels (Ruch, 2002). There may be a brief conscious consideration of my questions during conversations with practitioners. For instance, I may ask myself, could I have phrased that question better? Then there is a critical reflection which tends to take place following and between interviews. This is where I take the opportunity to reflect upon the content of the interview, my position, my social background, gender, race, and the values I hold that may influence the questions. Through this reflective process I am able to consider my thoughts and feelings, concerning the interviewer-interviewee relationship. For example, in my interviews with district nurses, many of them were married mature women like

myself, and therefore I expected to develop a good interview relationship very quickly. However, this was not always the case (see p.97). As I have mentioned above, this reflexive activity took the form of writing observational notes as well as discussing my experiences with my colleagues. In the appendix I have enclosed a sample of my reflexive notes that I made whilst analysing the data (p.343).

### **Recording and documenting data**

Having discussed how I approached this project I now turn to the ways I recorded and documented the data. Essential to data collection is some form of permanent and retrievable record, which can be referred to at differing times following the interview event. For this study I utilized transcriptions of audio recordings and personal field notes.

#### **Audio recording**

The method I used for recording interviews was audio-taping. This was a useful method as I was able to concentrate on the topic and the dynamics of the interview (Kvale, 1996), without the distraction of writing copious notes during the interview. Video-taping was not an option at the time, as it was not possible to transport video equipment to the different interview locations. Because audio-taping does not record bodily or visual responses that a video recording would otherwise reveal, personal observational notes were briefly taken during the interview and were added to following the event.

Overall, there were two main practical problems encountered when recording. First some participants experienced a degree of self-consciousness when it came to taping. Usually

this did not last long as they became absorbed with the conversation. However to overcome this potential difficulty I utilised a small dictaphone which I placed discreetly to one side of the participants. Secondly, the quality of some of the recordings was poor. Often interviews with district nurses and social care staff took place in large offices or out patient departments where there were interruptions by other staff and telephones. It was in these situations that the reflexive notes became very useful when transcribing and analysing the data. During the course of the interview I would only jot a few words onto a note pad, so as not to interrupt the flow of conversations. These notes were then written up immediately following the interview event. I included in the notes the main themes discussed, the behaviour and notable interactions, which took place between the staff and myself.

### **Transcription**

It is argued by some authors that transcription is part of the interpretative process and a degree of analysis takes place at this level (Lapadat and Lindsey, 1999, Kvale, 1996).

All of the tapes were transcribed verbatim. The advantage of this method is that it provides a relatively comprehensive method for examining interview data (Lapadat and Lindsey, 1999). The disadvantages included the possible errors in the transcription process as a result of poor quality recordings and overlapping conversations from focus groups. Poor recordings and mishearing can create errors in the transcription process and ultimately alter meanings and interpretations (Easton, Fry, McCormish and Greenberg, 2000). As I was present at the interviews I thought there would be less errors if I transcribed the interviews myself. Therefore I transcribed all of the individual interviews.

However, for the focus groups transcribing was a time consuming process, so I obtained assistance from an experienced transcriber. I verified the transcripts myself through listening to the tapes as I read the accompanying scripts. For inaudible dialogue, I consulted my field notes and recorded my assumptions within the transcript. Often these unclear portions of dialogue would become clear once I had read the remainder of the script.

### **Developing useable conventions**

Generally as I was working with the data, I tended to use my own style of conventions along with my accompanying notes of the interview. For my own research purposes it was not necessary to record the length of pauses and make particular linguistic analysis as in conversation analysis. Particular behavioural responses such as tone of voice and laughter were noted in instances where it became part of the meaning or essential to describing the person's reaction to the topic. For example, particular district nurse focus groups would laugh and joke amongst themselves when discussing stressful and difficult situations. I have listed some of the conventions below.

**Fig 2. Transcription conventions**

<b>I:</b>	Interviewer.
<b>SW:</b>	Social worker
<b>DN:</b>	District nurse
<b>[***]</b>	Incomplete or incoherent statements
<b>[?]</b>	Uncertain words
<b>[ ]</b>	Overlap of words and actions were placed in parenthesis at the point of overlap
<b>(Laugh)</b>	Behavioural responses placed in brackets
<b>LETTERS:</b>	capital letters indicated utterances spoken loud
<b>-:</b>	Pause or end of sentence
<b>...:</b>	Sentence broken off

### **Analytical strategy**

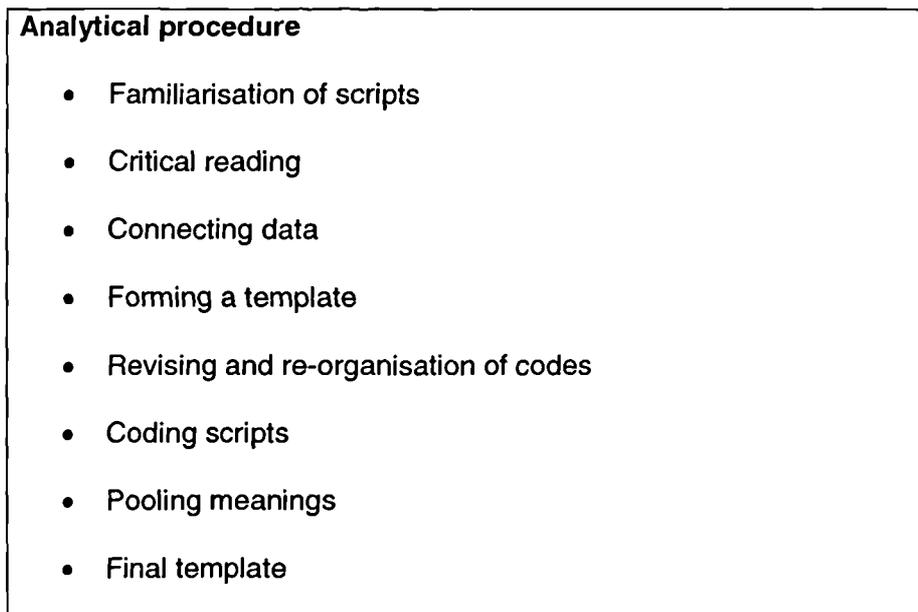
It was anticipated that the product of the analysis would be a comprehensive interpretative account that would highlight everyday meanings of district nurses and social service staff. As I have already mentioned earlier (p.60), the interpretative phenomenological analysis is best described as a cyclic process, a critical moving back and forth between the text, the notes and the codes. Addison (1999) described the process as

*'a circular movement from understanding to interpretation to deeper understanding to more comprehensive interpretation'*  
(p.155).

In practice it was important to utilise an analytical strategy that would aid this way of interpretation of data. A particular efficient and useful organising style is the template analysis or codebook (King, 2004, Crabtree and Miller, 1999). This way of analysing and organising data resembles Interpretative Phenomenological Analysis (Smith et al. 1999), and is able to deal with large groups of data effectively. Template analysis is a form of hierarchical coding which provides the flexibility, well suited to constructivist methodology. The interpreter is able to focus on particular aspects of text (or large chunks of text) and identify main themes, rather than becoming immersed in line-by-line detail. From the emerging themes, an initial framework is formed (the template) which undergoes revision, until all the main areas of interest are exposed. These themes are grouped together to form broad codes for the main areas of interest, and lower order codes are formed for areas of specificity. This style of organising allows the results to be structured without losing the variety of responses, and will reflect any "commonality" in the responses.

Detailed descriptions of how I formed codes and templates for the studies, is given in the following chapter. However, for an insight into the technique I have listed the procedure below.

**Fig. 3 Summary of Template Analysis**



**Verification of analysis:**

Once the template is formed corroboration is recommended to reinforce the plausibility and credibility of the interpretation (Crabtree and Miller, 1999, King, 1998). Earlier authors recommended member checking (Mays and Pope, 1996), whereby participants confirm analysis and interpretation. Silverman (2000) points out member validation is a useful exercise and a valuable source of data, although it is questionable whether validation is achieved. Other researchers using this approach found that participants were not necessarily reliable when asked to evaluate the scripts, nor had the skills to critically scrutinise the analysis (Bloor, 1997). On balance, I proposed that the most suitable and useful research action is verification with an independent researcher familiar with the analytical style. Therefore, I contacted a willing research colleague, informed her of my research aims and asked her to perform an initial template analysis for a selection of transcripts from my first data set. We then met up, compared notes and discussed the

themes that emerged from the data. Due to a lack of accessible qualitative researchers, for the remainder of the studies my supervisors scrutinised and questioned my analysis and conclusions. Also, some of the analysis and findings went into the evaluative reports for the district nursing service, and these were examined by the district nurse co-ordinator and support manager.

### **Quality and usefulness of Qualitative Research**

Quality within traditional positivistic research is ensured by rigorous procedures tested for validity, generalisability and reliability. Furthermore it becomes easier to establish and maintain criteria where there is consensus within the scientific community. These criteria are not so obvious amongst qualitative researchers where there are diverse views concerning research and where the philosophy emphasises creativity, exploration, flexibility and freedom of spirit (Guba, 1990).

Constructivist views would argue validity, reliability and generalisability stem from quantitative tradition and therefore are irrelevant (Seale, 1999, Kvale, 1995). Likewise, other authors would argue procedures will not necessarily produce sound data or credible conclusions, and a good methodology is not necessarily an assurance of good quality work (Whittlemore, Chase and Mandle, 2001, Seale, 1999). Although the issue of quality within qualitative work is not easily resolved, I take the view of those authors who would argue that qualitative research is a distinctive paradigm, whereby an alternative baseline for assessing and maintaining quality within qualitative research is necessary (Lincoln and Guba, 1985, Guba, 1990, Murphy et al. 1998.). However to assess the quality of this

work I suggest replacing the traditional 'trinity' based on truth values with transferability, auditability, and plausibility.

### **Transferability**

In contrast with generalisability, direct comparability with other settings is considered inappropriate. It is acknowledged here that some similarities do exist between individuals and situations, which have some potential for transfer (Lincoln and Guba, 1985). It is accepted within the following studies that there may be findings, which will be considered useful outside the original context of this study, and which may be applied to another context of a similar nature.

### **Auditability**

Given that neutrality and objectivity are unachievable, provision of an 'audit trail' gives a transparency that allows other researchers to examine the process by which researchers have arrived at their research decisions as well as their conclusions (Seale, 1999, Murphy, 1998). It is the intention of this inquiry to provide an account that is sufficiently coherent and comprehensive, so that another researcher could analyse the data in the same way and arrive at similar conclusions as the original inquirer (Mays and Pope, 1996).

### **Plausibility**

As a result of the methods employed (reflexivity and bracketing) it is anticipated that this project will present findings that are fair and credible, and will represent a number of different standpoints (realities). Furthermore, it is hoped that other professionals may recognise or identify with some of the experiences contain within the studies, and

therefore be challenged by the questions that may arise from this thesis. I will return to this later in the chapter.

## **Overcoming Ethical Nightmares:**

### **Reflections on emerging ethical issues and dilemmas**

Closely linked with maintaining quality in research are the ethical values that underpin the research decisions and actions. This is a potential minefield and the danger is that one can become so focused and enthusiastic with the project that little consideration may be given to the manner in which research is conducted. Therefore, at this point I wish to present a reflective account concerning the ethical issues related to the overall project and some of the ways that I overcame the dilemmas that arose from the studies.

Ethics may be defined as

*'The study of those assumptions held by individuals and organisations and professionals that they believe will assist them in making sound moral judgements'* (Bersoff, 1997,p.xi)

From a constructivist viewpoint I argue that researchers will construe ethics and the 'rightness and wrongness' of research acts in differing ways. Ethics will also vary according to the projects and circumstances and therefore, we need a flexible method to take into account the variety of situations encountered. For the purposes of this project I took a very pragmatic approach and adapted codes of conduct from several sources (Koocher and Speiel, 1998, Beauchamp and Childres, 1994, Rosnow, 1997). Also, I included the codes laid down by the BPS (2000), local research committees and clinical governance recommendations (DOH, 2001), as these reflected the attitudes of the research

community and the local professionals I was working with (Kimmel, 1988). The different sources I drew upon echoed similar concerns over the well-being and protection of the participant, the competency of the researcher, responsibility and accountability and the potential benefits as a result of the research (Koocher and Spiegel, 1998). Therefore, I will discuss these points under the following themes: research that is worthwhile and beneficial, responsibility and accountability of the researcher, dignity and well being of participants, and a faithful and plausible account.

### **1. Research that is worthwhile and beneficial**

The first consideration before embarking upon the research is to ensure that the project is worthwhile and useful in terms of effort, time and resources for both the organisation and the professionals involved. A recent research governance publication states that...

*'Research which duplicates other work unnecessarily or which is not of sufficient quality to contribute something useful to existing knowledge is in itself unethical'*

(DOH, 2001, p.15)

One way to ensure that research is worthwhile and useful is through approval from local research ethical committees, steering groups and project supervisors. This study gained approval from the university research committee as well as from the local research committee within the local NHS Trust. Also, a steering group was established that consisted of other experts from both within the Trust and the university. This included a primary care trust manager, district nurse co-ordinator, heads of community studies and a reader in psychology. Those within the steering group had an understanding of qualitative methods, and recognised its usefulness and application to primary care research. The

members of this group guided the research concerning the best way to approach the practitioners within the field and helped to resolve the dilemmas that arose concerning confidentiality and anonymity.

Confirmation of the usefulness of this project came through feedback from presentations at conferences. During the differing stages of research, aspects of the work were publicised, and presented at various conferences and seminars. These are listed in the box below.

#### **Fig. 4 Presentations**

1. Ross, A., King, N., and Firth, J (2005) Inter-professional relationships and collaborative working: Encouraging reflective practice. *Online Journal of Issues in Nursing*, 10 (1) Manuscript 3.  
Available: [www.nursingworld.org/ojin/topic26/tpc26\\_3.htm](http://www.nursingworld.org/ojin/topic26/tpc26_3.htm)
2. King, N., and Ross, A (2003) Professional identities and inter-professional relations: Evaluation of collaborative community schemes, *Social work in Health Care*.38 (2): 51-72.
3. Ross, A., King, N., and Firth, J (2003) *Roles and identities in the health and social care professions: A PCP method to enhance understanding*, Paper presentation International, PCP conference University of Huddersfield UK.
4. Balen, R., King, N., and Ross, A (2002) *The Professional Identities of Welfare Practitioners*, Paper presentation: Congress of the International Association of Schools of Social Work, Montpellier, France
5. King, N., and Ross, A (2001) *Professional Identities and Diversities and Inter-professional Relations*, Paper presentation: International Conference, Social Work in Health and Mental Health, University of Tampere, Finland.
6. Ross, A., and King, N, (2000), Yren seminar, Bradford UK.

It was desired and anticipated that the research process and findings would be of some benefit for the professionals who had given up their valuable time to participate. It appeared that many participants had volunteered because they were interested in the research topic and felt they would gain from the experience. Feedback from interviewees following the interviews indicated that they had found the experience to be beneficial. In the first study one student commented on how the interview helped to clarify her own

thoughts concerning her occupational hopes and expectations. The focus groups in the second study formed a major part of an evaluation report and assisted in the development of the service studied, and in the final study many of the district nurses felt that the interview process helped them to think of new ways of approaching their work.

## **2. Responsibility and accountability**

For this project I was accountable to my supervisors, director of studies and to the community manager within the steering group. My overall responsibility as a researcher was the conduct of research at operational level and according to the research governance framework (DOH, 2001),

*all those involved in research also have a duty to ensure that they and those who manage are appropriately qualified (p.17, 3.1.1).*

I had gained some basic understanding of ethical issues as a result of my nursing and midwifery background as well as in my capacity as a psychology undergraduate. I was used to sensitive issues and considered myself adept in interpersonal skills. Building upon my background I had observed and gained experience in conducting individual and group interviews from a previous evaluative study as a research assistant. However, it is all too easy to become blasé and familiar with certain aspects of confidentiality and anonymity; therefore, it was helpful to re-examine these concepts. I sought further knowledge from qualitative research seminars, conferences and courses both from within the university and externally.

For this project the ethical guidelines issued for health and social researchers within the NHS (DOH, 2001) were not that helpful, as they understandably focused upon patients rather than employees. In addition, the research guidelines were based upon the traditional positivistic epistemology, which was concerned with standards of clinical of practice and minimisation of risks, with little consideration of qualitative research. In the same way the local research committee in the Trust at the time were unsure of how to deal with qualitative research projects, they compared qualitative measures against the perceived 'gold standard' of randomised controlled trials. However, where I lacked experience and needed advice I was able to draw upon the knowledge of other experts such as my supervisors and director of studies and those working within the field.

### **3. Dignity and well-being**

There is a consensus of opinion that the primary consideration for any researcher when conducting the project is that the dignity, rights and the well being of participants is upheld throughout the research process (DOH, 2001, Koocher and Speigel, 1999, Kimmeel, 1988, Oliver, 2003). This usually includes informed consent, some surety of confidentiality and anonymity, and an assurance that there would be no personal or occupational repercussions as a result of participation within the study. However as King, (1998b) points out, both the interviewer and the participant are in an equally vulnerable position when it comes to collecting data and interpreting findings in real world research. Therefore, the welfare of both the interviewer and participant need to be considered during the following stages of data collection process.

### *i. Prior to data collection*

Those who were involved in the research process were informed of the aims of the project and how the data would be utilised. The latter varied within the studies. For instance, in the case of the second study the data formed part of an evaluation report and was part of my thesis investigating inter-professional working. In addition, I communicated to students and staff that there was no obligation to participate in the study, and that non-participation would not affect their studies or career progression. There were different strategies in communicating this information, taking into account the different participants and services accessed. For the first study, undergraduate volunteers were gained through announcements in their class sessions and were then contacted by phone, where further information was given about the nature of the study. (Chapter 5 p. 88). In contrast, the social care staff in the second study were informed of the aims of the study through a letter, followed by a telephone call.

Informing the participants is one issue but ensuring that the information is understood is another. Through talking with the participants about research, it became apparent that the participants had an understanding of research process and many of the practitioners had engaged in some research or audit activity.

### *ii. During the interview process*

During the course of the interview participants may disclose information that they may feel will have repercussions later. Also, there may be aspects of their discussions, which participants may not want to be included in the findings. Therefore at the beginning of the interviews I informed them of their rights to ask questions and to withdraw. Also, I had

ensured that all participants knew how to contact me in case they wished to ask questions or withdraw at a later stage.

I had mentioned earlier that an in-depth interview may place the interviewer as well as the participant in a vulnerable position and as King (1998b) argues, this type of interview can be likened to a counselling situation. Often during the course of my studies there were some individuals who would disclose personal difficulties they were experiencing in their work either before or after the interview. Also, there were occasions where I felt more vulnerable than others. On two occasions, I found myself as a lone interviewer conducting a focus group with very discontent staff as a result of organisational changes they were experiencing. During the course of the discussions emotions seemed to run high as they expressed their anguish at 'unfair' treatment by the organisation. In this case I had empathised with their cause and stated that their views would be included in the evaluative reports. On such occasions the interview schedule was a useful guide to facilitate the steering of the focus group in a constructive direction. In addition, my listening and diplomacy skills gained through my previous nursing experience stood me in good stead in dealing with this awkward situation.

Overall, conducting focus groups could be both mentally and emotionally exhausting, as I facilitated discussions that were at times sensitive and potentially volatile. As I have pointed out earlier there were times where practitioners saw the interviews as an opportunity to share their personal feelings and unload their concerns. In such situations the participant(s) and I (the interviewer) required time for debriefing. Therefore,

following interview situations I would allow time for relaxed discussions and perhaps a talk through of any issues that were raised. For my personal well-being I shared my experiences with other research colleagues and my supervisory team.

### *iii. Dealing with data and personal information*

During the course of the research project it became imperative that I formed some protocol concerning the access, storage and retention of data and personal details.

The data consisted of tapes, transcripts, field notes, names and telephones lists. These were stored in places to which only I had access. For instance, whilst working in the research office data and personal information was stored in a locked cupboard, otherwise it was stored at home in my personal office.

For access to interview data I followed guidelines prescribed by the Data Protection Act (1998). Information was not passed on without the knowledge or consent of the participant. In addition, it was accepted that participants had access to their own data and the primary investigative team; which comprised myself, the director of studies and the project supervisor.

For retention of data and information, it was anticipated that original tapes would be stored until completion of the thesis, after which tapes would be destroyed. However, the research team would keep transcripts of the tapes for secondary analysis and further academic writing.

#### *iv Anonymity and identifiable participant information*

Protection of the participants in the reporting and representation of the analysis was ensured by replacing names of places and individuals with pseudonyms. However, on occasions it was possible from the descriptions that some participants would be recognised by other members within the team or organisation. For instance, the students were drawn from the local university where my project supervisor was also the head of community nursing studies. Therefore, there was a possibility that students participating in the study may be recognised by my project supervisor. Another situation arose within the second study when there was only one member who held a particular occupational position and who therefore may have been easily identifiable by others within the organisation. In these cases I discussed at length with the parties involved and the steering groups how I might preserve anonymity and present the findings. It was agreed in many cases descriptions of those involved would be kept to a minimum, sufficient for the needs of the study.

#### **4. Provide a faithful and plausible account**

I have already discussed in the previous section (p. 72) the principles of how I intended to present a plausible and multifaceted account. However, in practice there were two main dilemmas that emerged from the studies concerning the presentation of the data. One was including quotes that may be construed as harmful to future relationships with other practitioners. For example, there were quotes that emerged from the focus groups that displayed discontent towards other staff groups. This revealed important aspects to what was going on at the time between different staff groups as a result of service

developments. Therefore, it was pertinent to include such quotes within the study. The second dilemma in presenting findings was the inclusion of some quotes, which may be construed by managers as a poor reflection of the service, or as highlighting their weaknesses within the practice, which may affect future funding. In both of these situations good relationships and the development of trust with the district nurse managers proved valuable. With support gained from my project supervisors I was able to reassure managers that a fair report would highlight the benefits of a service as well as uncover its' weaknesses, and therefore would enhance understanding in a constructive way.

## **Conclusion**

This chapter has outlined the philosophical and methodological position towards exploring ways that district nursing and social care staff construe their identity in joint working events. It has clarified how a constructivist phenomenological approach is appropriate to the aims of this project study, and how the methods and the manner in which this research was conducted overcame some of the dilemmas that emerged. Further details with regards to the methods of data collection and analysis are provided within the relevant sections of each study.

The next six chapters present the empirical studies of this thesis and demonstrate how the application of a constructivist phenomenological approach uncovers detailed accounts of beliefs and values in the every day experiences of district nurses and social workers. Chapters 5 and 6 detail the student study and provides a background of the expectations,

beliefs and values gained through the socialisation process. Chapters 7 and 8 provide an account of district nursing and social care staff during a time of service development and organisational change. Finally, chapters 9 and 10 provides individual accounts of inter-professional relationships during everyday joint working events.

## **Chapter 5.**

### **Study one: Beliefs and Learning experiences of student care professionals.**

#### **Part one. Introduction and Methodology**

The overall aim of this thesis is to explore the ways district nurses and social workers construe their identity, within the changing context of collaborative working. The first study is concerned with examining the students' concepts of what it means to belong to a particular occupational group and the influences that shape their ideas and practices. Furthermore I aim to explore how these student groups understand their professional identity and roles when working with other professionals, and the ways they believe their training has prepared them for joint working practice. This study is presented in two parts. The first part outlines the methodology used and the background to the study, and the following chapter presents the findings and discussion.

#### **Methodology**

My primary concern was to uncover and articulate how individual students within professional occupational groups construed and organised their world in a meaningful way. Following the constructivist phenomenological approach, as outlined in the previous chapter, I utilized individual semi structured interviews and template analysis (King, 2004). This enabled me to explore and appreciate the culturally and historically situated interpretations of the professional world, and the differing meanings that students may bring to joint working situations. (Crotty, 1998, Schwandt, 1994).

## **Sampling**

My intentions for this first study was to gather a sample of social work and district nurse students who were training within the same educational establishment, local to the intended area of the other studies (see chapter 6 and chapter 8). I therefore approached the course tutors of the health and social work department at a university in the North of England.

The main inclusion criterion was that all participants had some placement experience of working with other professionals and their clients. I therefore decided to approach the students in their last year of training. The district nursing and social work student groups that were available to me at the time had a larger number of females than males, which reflects the higher proportion of females within the care professions (Pizurki et al. 1987.) I attempted to include some male representation from both sample groups, but in the final outcome I was unable to arrange a suitable time with one of the male social work students. The size of the sample would largely depend on the variety of accounts and experiences of the students. For practicalities and accessibility, it was anticipated to include a maximum of ten students.

## **Background**

Having decided upon a sample criterion, I contacted and gained permission to access students from Houghton University. At this point I will provide a brief background of the health and social work training programme at this particular university, thereby exposing

the complexity of gathering these participants as well as contextualising the data. To ensure anonymity I have replaced personal and town names with pseudonyms.

### **The School of Community Health and Social Care: Houghton University**

The school provides education at degree and master level for many aspects of health and social work. Furthermore, it is important to mention that at the time of the study, the courses provided by this school for undergraduate community nursing and social work were not integrated. Largely, undergraduates were educated within their separate courses and had little classroom contact with students from other occupational courses. However there were a few taught modules that included a 'mix' of other students, for example, the 'Child protection module', where social work students were joined by health visitor students. I will now outline the training courses for district nurses and social workers.

#### **District nurse training**

The BSc (Hons) Community Specialist Practitioner course at the School of Community Health and Social Care underpins many community nursing careers, including general practice, health visiting and district nursing. For access onto the course all applicants are required to have a previous nursing qualification and usually some community experience. Since the majority of the students I interviewed were considering the district nurse pathway, I shall refer to these students as student district nurses.

The specialist practitioner course enables the student to study either, full-time for a year, or as a part-time student over two years. For fulltime students this means two study days

per week in the university and two days per week in practice. For part-time students, the hours are halved over a two-year period. This particular course comprises 50% theory and 50% practice in a placement other than their current place of work. At the time of the study, students were required to attain a competency level in both theory and practice as approved by the professional body (then the United Kingdom Central Council for Nursing Midwifery and Health Visiting), if they were to qualify as district nurses.

### **Social work training**

The social work students interviewed were full time undergraduate students on a three year course leading to the B.Sc (Hons) in Social Work with the licence to practice (DipSW). As this is a qualifying course in social work, it is not necessary for applicants to have previous professional qualifications. However, some previous voluntary or social care experience is essential for acceptance onto the course. The course is validated and guided by the Central Council for Education and Training in Social Work (CCETSW). It was designed to prepare students to enter careers in social work, criminal justice and social welfare. Because of the diversity of practice, I shall refer to these students as social work students.

Similar to district nursing, to gain a licence to practice these students have to achieve an approved competency level both in theory and in placement. The first 18 months of training involved a theoretical foundation within the university, before embarking on supervised work placements in the community, known as 'the practice module'. This placement experience would comprise two blocks of four days a week for 17 weeks each,

and this takes place in the second year and third year of training. The remainder of the training time is spent within the university.

### **Negotiating access**

Following my initial contact with course tutors, gaining access to the district nurse and social work students was a complicated and a lengthy process. At times social work and district nursing students were on their 'placements', which were widespread across the region, and their study times within the university varied. In cases, this led to a rather protracted method of obtaining volunteers either through their personal group tutors or during study days within the university. Students who attended study days I met following a lecture, having made prior arrangements with the tutor. At these sessions full explanations of the project were given, and those interested in the study arranged an interview time directly with me. For the students who attended tutorial groups, the tutors were given an outline of the current project and details concerning the actual interview. It was stressed that there was no obligation to take part in the study, and their decision would not have any bearing upon their future studies. Those who wished to participate submitted their names and telephone numbers to their tutor who then passed them on to me. I then contacted each student by telephone, reiterating the details of the study and the interviews. Following the telephone discussions, if students were still interested and available, a mutually suitable meeting time was arranged.

On recruitment, I informed students how I anticipated the interviews were going to be analyzed and utilized as part of the research. Also, the students were given my telephone

number and informed of how to access me in the university if they had any concerns at a later date. This method of gathering participants and interviewing took place over a period of six months.

### **Introducing the participant groups**

From the follow-up contacts I interviewed a total of ten undergraduates attending Houghton University; five district nursing students (four female and one male) and five social work students (all female). This provided the desired assortment of accounts and experiences, demonstrated below in the introductory summaries.

#### **The district nursing students**

At the time of the interviews this group of undergraduates were in the final year of their course. The first four students were part of the same training cohort, had completed their dissertations and were about to sit their final exams. Many of these students were experiencing time pressures associated with work and study. They were currently employed by local healthcare trusts as staff nurses, but all were prospecting for district nursing posts. The variety of experience between the students is illustrated below in the brief character summaries. Here I have outlined their motivations for training, their interests and their future aspirations.

1. **Dot** is 38 years of age. She has worked in the community for some time, as a staff nurse and also as a nurse in residential homes. She particularly expressed her interest in and enjoyment of the holistic care of the individual in the community, in

contrast to the hospital approach to care. Upon qualifying she wishes to continue working in the community as a district nurse case manager or team leader.

**2. Peter** is a 25-year-old primary care nurse. He has been employed by the community team to support the health visiting, district nurse and practice nurse teams. For Peter, working as a generic nurse accountable to 3 different team leaders was good experience, but did have its drawbacks in terms of personal progress and development. Peter now wishes to focus on district nursing, which will enable him to seek promotion as a case manager.

**3. Sarah** is a 40 year old, who has been working as a part time community staff nurse. She has a wide experience of working with different practices in both urban and suburban areas. She is now undertaking the course as a part-time student, which will enable her to apply for a district nurse case manager post.

**4. Frances** is a 35 year old. She has been working in the community as a staff nurse supervised by district nurses, a health visitor assistant providing support for elderly people and a community care adviser for a Rapid Response Service. She is undertaking the training over a two year period to specialise in district nursing, as she wishes to broaden her nursing skills and abilities. Frances' interests lie in collaborative management projects, and at the time of the interview she had applied for a community management post.

**5. Sophie** is a 29 year old and has been working as a community staff nurse for the past 7 years. She is currently undertaking the community specialist practitioner course as a part-time student over a two-year period. Upon qualifying, Sophie intends to apply for a case manager post, where she will be the team leader or caseload holder. At present she is uncertain of what specialty she will pursue, although she is moving towards an interest in wound and palliative care.

### **The social work students**

Many of these students were about to embark upon their final practice placement, having completed another teaching block in the university. Lynn was the last I had interviewed and had just completed her placement. It was quite a pressurized time period for these students as they had many assignments and a dissertation to produce, coupled with seeking future employment. The diversity within this group of students is demonstrated below, where I have provided character summaries of the individual social work students.

**1. Sandra** is 32 years of age, and has been working for the past 6 years as a casual residential social worker for the local authorities. She has a wide experience in social care work with mental health and special needs; for both adult and children's services. Sandra originally embarked upon the course to specialise as a social worker in special needs services, partly as a result of previous experiences but also because of her interest in sociology and politics. During her training she has found the tensions between the values taught and the organisational constraints particularly frustrating. At the time of the interview she was considering a career change.

**2. Miriam** is 42 years of age and describes herself as having a 'disability', which restricts her access to certain buildings. For the last nine years she has been actively involved with children's voluntary work and charities, as well as caring for her own children. The satisfaction she gained from these previous experiences prompted her to embark upon this course. Miriam is very keen to complete this course because she enjoys her practice placements and hopes to gain work in a voluntary agency, working with children and families.

**3. Ruth** is 28 years of age. She supports her studies by working part time as a care worker with children with learning disabilities. Ruth has a wide experience in residential care as well as caring for a disabled relative. Ruth describes how the course has caused her to reflect on cultural differences and has enabled her to adjust to the different situations she may find herself. Ruth's interests now lie within mental health. She looks forward to practicing and hopes to eventually pursue the Approved Social Work status in mental health care.

**4. Trish** is 35 years of age and became progressively interested in social work as a result of various adult education courses, which finally culminated in the completion of a BTEC, prior to social work training. Her broad voluntary and residential experiences include working with HIV organisations, residential care and working with the elderly. In addition she feels having 3 children of her own has given the stability and the maturity to pursue her social work interests. Trish now wishes to

practice as a social worker in the area of children and families for about 3 years, and then she will consider an adult specialty.

5. **Lynn** is 39 years old, and has worked for 10 years in residential care work for people with learning disabilities and mental health disabilities. Prior to having her daughter, Lynn worked as a domestic assistant in a residential hospital for learning disabilities, then as a care assistant for social services. Other experiences included working in nursing homes and providing home support for a friend's mother. Lynn has had a lot of social work contact throughout her work and family life. Social care work was something she had grown up with, her parents fostered children and her father worked with people with learning disabilities. Lynn wishes to practice as a social worker with disabled adults.

## **Data Collection**

### **Location**

All of the students preferred to be interviewed at the site of Houghton University, largely because of the convenience of arranging interview times around their studies, lectures or tutorials. The interviews took place either in a classroom (four district nurses) or within my office (one district nurse and five social work students); again this decision was taken by the student and was a choice of convenience.

All interviews were tape recorded with the students' consent and lasted from 45 to 120 minutes. Students were given the option to withdraw at any time during the interview process and were reminded of my telephone number, in case they had any queries and

wished to contact me following the interview. Incidentally, none of the students chose to take this up.

### **Semi-structured individual interviews**

To reiterate, the constructivist phenomenological position claims that people's meanings are not simply transparent. However, by inviting the students to describe their occupational roles and views, I take the opinion that it is possible to access their meanings and the way they construe their experiences through informal, semi structured interviewing (Smith, 1995, Kelly, 1963). The advantage of this style of interviewing is that it gives me the freedom to probe areas that may arise through the discussions, and to be able to follow up areas that were of interest to the participant (Smith, 1995). Nevertheless, it is sensible to prepare some form of schedule prior to the interview, to guide the interview and provide cues when the interviewee is struggling. On reflection, I found that the process of designing the schedule gave me an opportunity to consider those areas that I wished to cover, as well as think about the most appropriate way of phrasing the questions.

#### ***i. The interview schedule***

I utilised a phenomenological approach to interviewing (bracketing and epoche) to gain an overall picture of the '*way things might appear*' to the students (see chapter 4, p. 59); what '*Kelly calls the credulous approach*' (Butt, 2004, p.134). Therefore I needed to design a schedule that would encourage the students to tell me about their working lives, what was important to them, as well as how they may interpret their experiences. For

phrasing questions I gained ideas from Robson (1998), Webb (1995), and Leitner (1985). Since the aims of this study was to explore how practitioners negotiated their professional identity with others in joint working projects, the schedule design (fig.5), was to encourage students to describe their occupational roles, how they came to choose their course, and their views concerning professional training and practice. I included questions that would encourage students to share their views concerning their relationships with other professionals, their clients, and to discuss their experiences of joint working practice. As I mentioned above, the schedule was used to guide the interview, not to dictate the sequence or the direction of events. To ensure that the questions made sense, before I started interviewing I tested some of questions and ideas on fellow research students and asked advice from research supervisors.

## **Fig. 5 Interview Guide**

**Preamble:** Personal introduction : Aims of the interview: Anonymity and right to withdraw

### **Background of student**

Can you tell me a little about your self, who you are and how you came to choose this course?

### **Identity and roles**

Can you tell me a little about the work of a social worker/district nurse?

[How do you see your role?]

What do you like about being a social work/district nurse? –Why?

What don't you like about it? - Why?

How do you think others view your occupation?

- Professionals
- Public
- Clients
- [Do you regard your occupation as a profession? - Why?]

### **Joint working**

How would you define joint working? /What is your understanding of joint working?

Have you worked with other professional groups?

What do you do that is different from other professional groups?

How do you see the role of (district nurse/social worker) when working together?

Can you give me an example when joint working went well?

Can you give me an example when joint working did not work so well?

### **Student experiences**

How has your training helped to prepare you for your future role[s]?

What sort of support do you have at the university? -Friends, tutor, etc.

Do you 'mix' with other students from other courses?

Do you have lessons with other students who are on other courses? ; Health /social students etc.?

How has your training helped you to work with others?

## **ii. Interview experience**

Overall the interview guide (above) served me well, as in most situations the questions encouraged lengthy and informative conversations with the students. It provided me with a good back up with some students when conversations ran 'dry'. However, in many cases not all the questions were asked, as other areas were pursued and the order of questions varied according to how the participants responded.

At this point I will briefly describe some of my overall impressions of my interviews with the students, in terms of the type of rapport I developed with the students and their

responses to the interview situation. In particular I noticed a marked difference between my interview experiences with the two student groups. To my surprise I found that I was able to develop a rapport swiftly with the social work students as they very readily divulged their feelings to me concerning their work relationships, their backgrounds and the dilemmas they faced as students.

In contrast I had an initial difficulty in developing the same open rapport with the district nurse students. I was surprised by this, as many of these students (like myself) were mature, married women, and appeared to have a similar background as myself. The district nurse students were very helpful and were willing to give me information, however there was not the same keenness in disclosing their feelings and opinions as compared with the social work students. Some of the district nurse students found it difficult to describe their 'everyday' actions of their work. Also, the dialogue with the district nurse students tended to need more prompts from me and they remained fairly focused, relating solely to their work roles rather than personal background. Moreover, I found myself feeling uncomfortable when probing beyond the occupational domain, sensing this would appear inappropriate. This may be due to the stage these nurses were in their career at the time of the interviews. From the participant summaries it is evident that the district nurses have completed a qualifying nursing course and have at least two years nursing experience. Therefore it is reasonable to suggest that the district nurses were acting strongly in their role when talking with me. In contrast the social work students were undertaking their foundational course and had not yet practiced as a qualified practitioner.

The other notable differences were in the way the district nurse students responded to controversial issues. For instance, social work students were more explicit and forthright in revealing areas of frustration or conflict, whereas district nurse students would respond with a 'knowing' smile or with humour as if to avoid further discussion.

On reflection, the differing interview experiences may have been due to a number of reasons, including my interview style and the order, location and timing of interviews. I had interviewed four of the district nurse students before the social work students; this was due to access rather than design, and perhaps I had not developed a confident interviewing style with these practitioners. Consequently, my interview presentation may have influenced the quality and depth of the responses (Fontana and Frey, 1994), although I would argue, having had a nursing background, interviewing nurses first would seem quite sensible, as I (naturally) thought I would feel at ease talking with these practitioners. Perplexed by this situation I began to examine the differences between the location and timing of interviews, including what had occurred prior to interview. Both groups of students were interviewed around their study days or tutorials so there was little difference there. I deduced then the emerging contrasting styles and experiences between the students groups were not simply the product of the interview situation but reflect more of the differences between the students. The possible differences I am referring to are as follows; the way the student groups are socialised, the way they approach their work, the way they are encouraged to interact with others, and the way they critically reflect upon their practice. These differences are explored further and become apparent in the findings below.

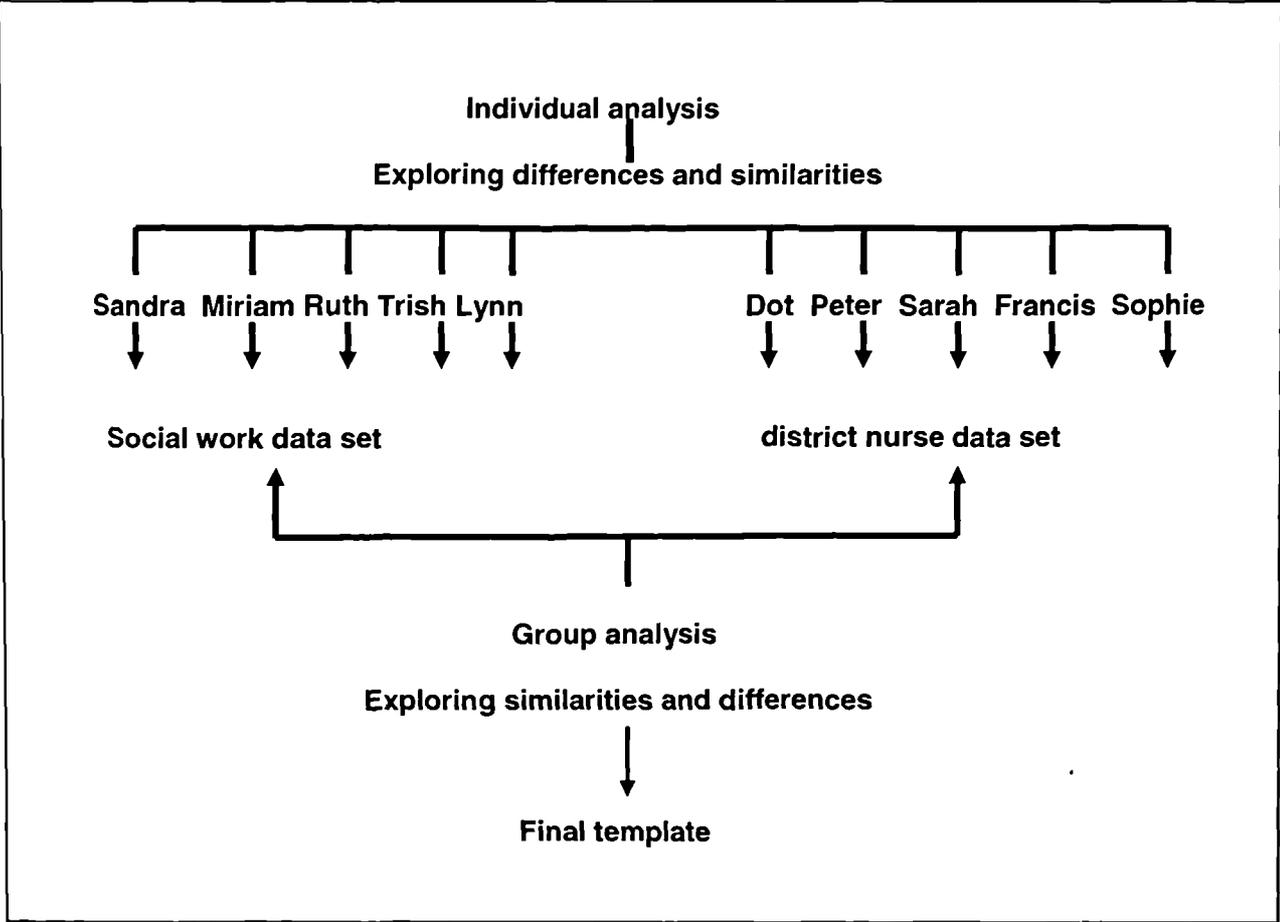
## **Analysis**

Since my aim was to uncover the practice and meanings of professional identity as experienced by these students, I intended to identify the commonalities and the differences between these two student groups. Template analysis (King, 2004) proved very useful in this, by way of facilitating close engagement with the transcripts, and as a method of structuring and organising large quantities of data. I will now describe my application of this process to the student study using the framework given in chapter 4.

### **Developing an analytical strategy**

Having decided upon my intentions towards the data, the next key decision was, what overall strategy should I adopt in the student analysis? Faced with a large amount of data, the obvious option was to separate the transcripts into two data sets; the social work students and the district nurse students. For each of the data sets, I used an initial template (guide) formed from the interview schedule and applied this to each transcript in turn, revising the template as different experiences and views emerged during the analysis. The result was two templates, which were then merged to create a final template. (See fig 8). I will now describe the process of creating the template.

**Fig. 6. Data set and analytical strategy**



**Creating the template**

**1. Familiarisation**

In creating the template, the first stage of the process was to familiarize myself with the transcripts. This gave me an overall picture of the content of the scripts, which then facilitated my decisions towards this analytical strategy. During the first reading, initial memos and notes were taken of the prominent issues and themes that emerged. Often these initial memos or ideas were written on the back of the script and themes written down the side of the margins. The notes were summarized into general topics and general impressions, and were then added to the front of the script as a broad summary. To these I added notes concerning the context of the interview and memos I had taken at the time of

the interview. The individual summaries were particularly useful reminders of the interviews as the data analysis became more complex and hierarchical (Smith, 1995).

## **2. Coding and connecting:**

Further reading of individual scripts led to some initial coding as I attempted to grasp the concerns and expose the underlying issues of each person. The prompts from the interview schedule served as guidelines in the formation of the broad codes. By constantly making lists of themes at the side of the scripts I was able to make connections between the data and the codes. Initially I developed five broad level one (or super ordinate) codes, bringing together general shared themes or experiences concerning the student boundaries and roles. Upon closer examination of the codes it became apparent that there was overlap between some of the definitions of the main emerging themes and therefore, this was reduced to the four main broad level codes summarized below.

### **1. Beliefs about professional identity**

### **2. Defining professional boundaries and roles**

### **3. Professional socialization and learning experiences**

### **4. Beliefs about joint working**

Themes that could not be categorised at this stage were placed to one side as 'Floating codes' (or 'free codes') and were incorporated if necessary at a later stage.

To the above broad themes I added lower order codes for specific emerging issues, which created depth and specificity to the analysis. Often it was the individual or unique responses that were assigned as lower order codes beneath these broad themes. At times it

was necessary to subdivide codes into as many four levels to include the diverse responses (see summary of codes pg 99).

### **3. Formation of the template**

From the process of looking at commonalities and differences between the codes I began to formulate a hierarchical list as a way of organising the data (King, 2004). This meant editing, revising and reorganisation the codes as I attempted to develop a fairly comprehensive template. At this point the employment of NVIVO, a qualitative analysis software package proved very useful, by facilitating the organisation and retrieval of data (Gibbs, 2002). As the list of codes grew I became aware of straying from the focus of the study. Corroborating with research colleagues helped me to maintain analytical integrity and alignment with the aims of the study (see chapter 4 p.66). Moreover, it was an opportunity for others to challenge my views and to highlight areas in the analysis where my bracketing may have failed. Once satisfied with my coding, I arranged to send a selection of the transcriptions to a research colleague familiar with template analysis, who proceeded to perform a basic template analysis. We then met and shared our interpretations of the scripts as well as our definitions of codes. Also, I discussed the themes and issues that emerged with my supervisors. The description of the final codes and template are outlined below.

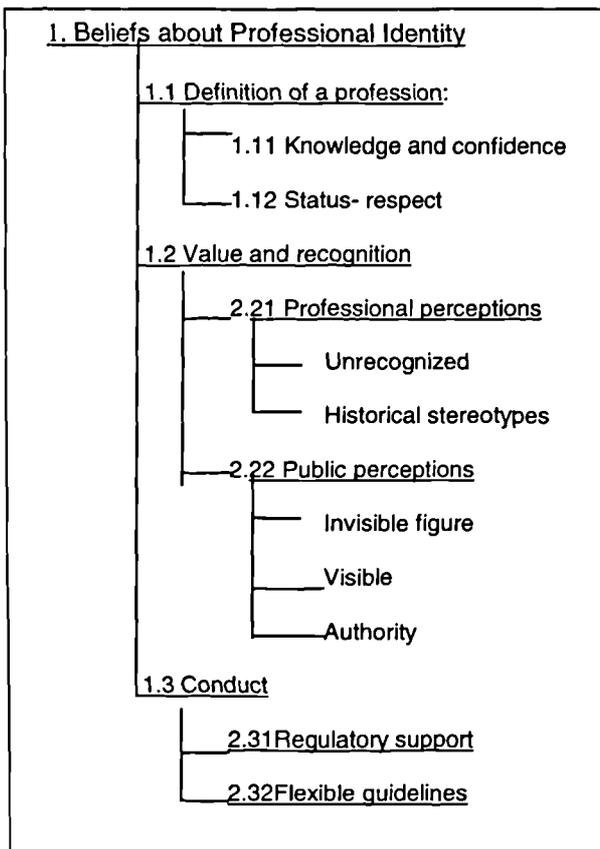
†

## **Summary of codes**

### **1. Beliefs about professional identity**

This encompasses issues surrounding the question of what constitutes a professional and how participants define themselves within those concepts, and the participants' beliefs and perceptions concerning other professional groups. Therefore this code comprises three level-two codes; *Definition of a profession*, *Value and recognition*, and *Conduct*. These level-two codes were further refined (as illustrated below) to expose the differences that emerged amongst the students and between the two student groups. The second-level code, *Value and recognition*, highlights how the students perceived their professional identity in terms of how they were recognized and valued by other professionals, the public and their clients. Whilst discussing their identity many of the students seemed to highlight the importance of conduct and how this was guided, and so this became the third second-level code.

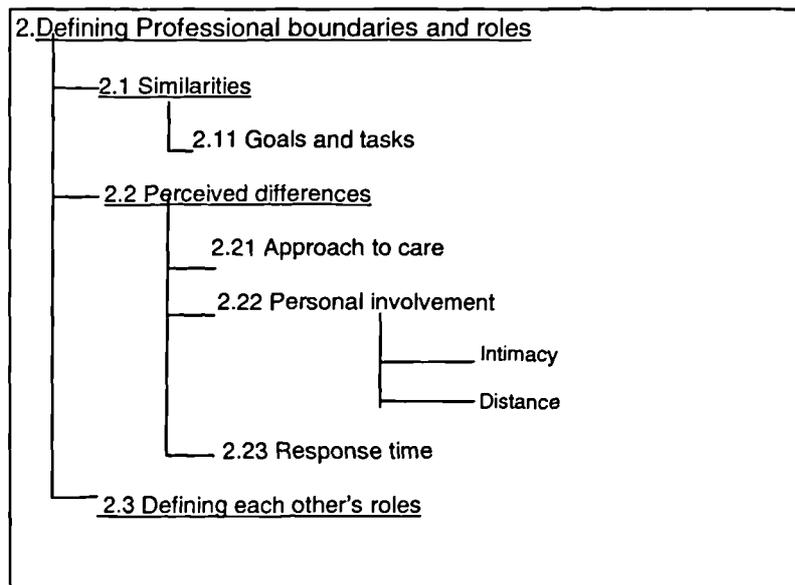
**Fig.7 Beliefs about Professional identity**



## **2. Defining Professional boundaries and roles**

The second broad (level-one) code refers to the way care practitioners construe their roles and boundaries. Through the reading of the scripts I found similarities as well differences between the student groups in the way they spoke about the client and their roles, therefore this became the basis of my level-two codes, *Similarities*, and *Perceived differences* of care. It was necessary to further subdivide the second-level two code- *Perceived differences*, to include the diversity of responses. These were, *Approach to care*, *Personal involvement* and *Response time*. I included a third level-two code to present the different ways they defined each other's roles.

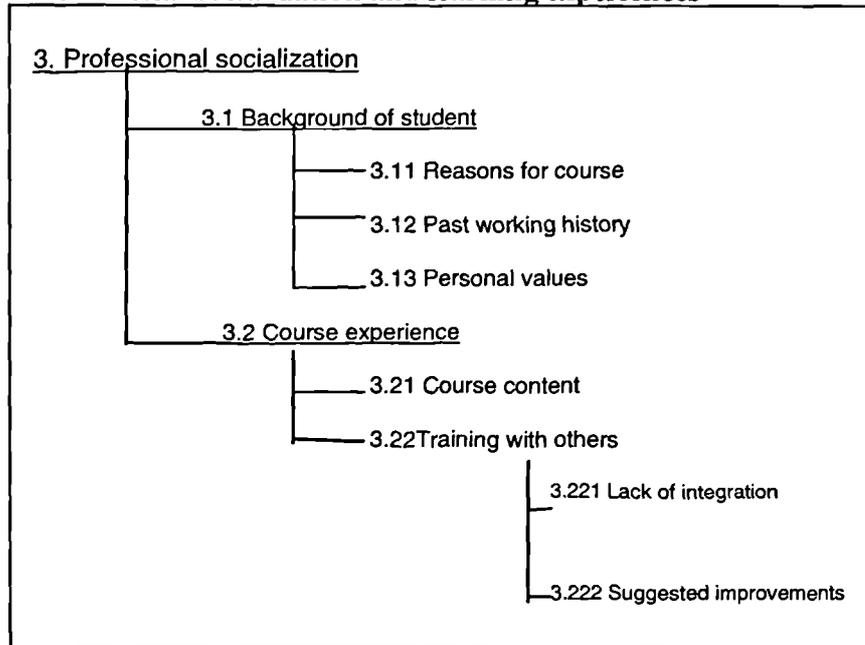
**Fig.8 Professional boundaries and roles**



### 3. Professional socialization and learning experiences

This third level-one code included both *Background of student* and *Course experience*, which were labeled as level-two codes. The first of these level-two codes is largely descriptive, with a further three third-level codes, to identify the influences that have shaped their career path. *Reasons for course*, *Past working history*, and *Personal values*. These were used to form the characterization summaries on pages 6-9. The second level-two coding *Course experience*, gives detail to the *Course content* but also identifies aspects concerning *Training with others*. I subdivided this code further into two level-four codes to include issues that arose due to the *lack of integration* with other occupational students, and to include the students' suggestions made concerning improvements they would make to their learning experience.

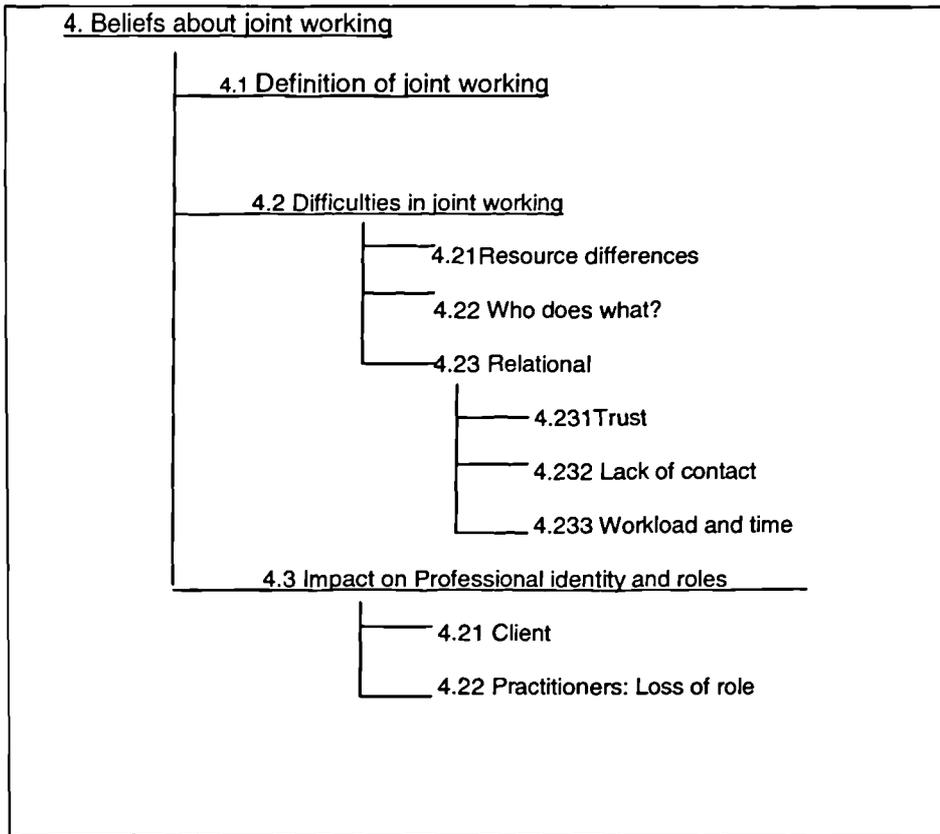
**Fig. 9 Professional socialization and learning experiences**



#### **4. Beliefs about joint working**

Finally this fourth level-one code specifically relates to accounts of joint working notions and experiences in practice. The first level-two code, *Definition of joint working*, is self-explanatory. The second level-two code refers to the practical *Difficulties in joint working*, as identified by the students. I sub coded this into three level-three codes according to the varying accounts of experiences. These include how they described their *Resource differences*, the difficulties they encountered over *Who does what?* And the *Relational* difficulties they experienced working with other practitioners. The final level-two code was applied to the comments that the students made concerning how they felt the changes in ways of working (especially joint working) impacted on their professional identity and role. This code was further subdivided to include comments concerning how the *Client* perceived the changed roles, and how some *Practitioners* believed they might lose aspects to their role- *loss of role*.

**Fig.10 Beliefs about joint working**



I will now present the findings and the discussion from this template in the following chapter.

## **Chapter 6.**

### **Study One: Beliefs and learning experiences of student care professionals**

#### **Part two: The findings and discussion**

This chapter consists of the findings and the discussion of the student care professionals study. First, I will present my findings by following the main headings of the template described in the previous chapter.

#### **1. Beliefs about professional identity**

In my attempt to understand what it means for the student to belong to a particular occupational group I found it useful to examine the following; how they defined what it was to be a professional, how they defined themselves within those concepts, how their practice was guided and how they thought others perceived their occupation.

##### **Definition of a professional**

From the analysis, it became apparent that for many of the students, to be a professional practitioner was not a label (or a status) acquired solely upon qualification or through training. Rather, it was a confidence and a knowledge, which they would gain by experience, and was expressed in the way they worked.

##### **Ex.1.1**

*Trish: Yeah, the more experienced ones that I've worked with definitely. I regard them as professional because they are experienced. They know what*

*they are doing and they know what action to take, whereas I need advice.*

(Social work student)

The social work students did not exude this confidence that Trish spoke about, and I attributed this to the lack of fieldwork experience and that they had not yet started to work full-time as social workers.

In contrast the district nurse students would refer to themselves as professionals or that their occupation was a profession. Also, they radiated a self-assurance and confidence in the way they spoke about their differing experiences, which was not evident with the social work students. This is possibly attributed to the overall experience of the student district nurses, as all of these students had been practicing as qualified nurses, and in Trish's words appeared '*to know what they were doing*'.

Unlike the district nurse students where there was a high degree of consensus, the social work students held differing views of whether their occupation should be regarded as a profession. For Sandra, a professional, was recognised by clients and other practitioners as having a credible accountability process, which she felt social work did not have. Lynn, on the other hand, felt that the term 'professional' was a label to describe someone with a specific learnt skill. Therefore, she believed that social work was best described as a vocation rather than a profession, because of its caring values and holistic approach to care.

### Ex.1.2

*Lynn: It's a vocation... A vocation is something that is in you, that's it for me. A lifestyle. If you have a vocation it is the way you are, you can either do it or you can't do it. A profession is something that you train for, you can go through your training, you can do it, and you don't really have to care about it you know.*

(Social work student)

For Lynn social work was a way of caring which was not necessarily taught. If you refer back to the introductory summaries (p.97) it can be seen that Lynn had gained her ideas about social work from her parents at a very young age. Therefore social work and caring for Lynn was a way of life - a natural way of thinking and acting which did not have to be thought about in a conscious way. On the other hand, the term 'professional' was construed as a way of working which was separate from caring; the practitioner could perform a skilled task but could remain unconcerned or indifferent towards the person.

#### **Value and recognition**

However, to be a professional emerged as something more than being competent in a particular skill. In many cases it was defined as having their expertise and contribution to care acknowledged by others - namely other professional groups, the public, and more importantly, their clients. First I will present how these students perceived the way other professions construe their occupation, followed by the way they construed their clients' and public's perceptions.

### **Professional perceptions**

There were numerous comments from social work students concerning how they believed other professionals valued their work. They tended to perceive that other professionals viewed their occupation as the '*bottom of the pile*', and their role as either '*a waste of time*' or that they '*add to the problem*'. Some of these comments came from experiences when working with other professionals. Interestingly, no such comments were made about social workers by the district nurse students I interviewed.

The social work students also made references to current government policies where there was perceived to be little favour or financial support in comparison with the health service.

#### **Ex.1.3**

*Sandra: The last amount of money that was going to be dished out between the NHS and the Social Services. The NHS got all of it, because it is a bigger political hot potato than Social Services.*

(Social work student).

Many of the social work students shared the above viewpoint and this appeared to strengthen the feeling that other professionals viewed their occupation as relatively unimportant. As Trish remarked, '*it's (social work) just doesn't seem recognized!*'

Some of the social work students explained this lack of recognition as due to the type of work they did and that their job roles were not so sharply defined as other professions. Often the approach and type of social care would alter according to the location,

availability of resources, and individual evaluations of the situation. Trish describes below the difficulties that arise for social work as a result of its diversity.

Ex.1.4

*Trish: Social work, it's kinda like nowhere really, it's not particular on any agenda at the minute. They (government) are trying to find whether to put social work under health kind of umbrella or the housing umbrella because it's nowhere. We fit under so many different slots!*

(Social work student)

The multiplicity of their roles meant that others did not recognize them as having a clear occupational domain or specialty. They described their position as occupying a 'no man's land', where there was a danger of being overlooked by government in terms of resources, and overshadowed by the health service.

In spite of these concerns, many of the social work students were not overly disturbed by the low evaluations of their work. On the contrary, it was as though they had accepted such views as what went with the work. The apparent indifference to their professional image can be explained further by Miriam's response.

Ex.1.5

*Miriam: I think if you were to ask them (other professionals), the ones who we have been involved (with)-. We are not a waste time.*

(Social work student)

Although I detected a hesitancy from Miriam's' comment, I sensed where it really mattered for her was at operational level. This was where she actively engaged with other

professionals in client care, where she gained a sense of recognition and understanding for her work, regardless of the generalized and uncomplimentary comments made about her occupation.

In contrast, for many of the district nursing students it was important that their expertise was acknowledged by certain practitioners, as illustrated by Frances below,

Ex.1.6

*Frances: I don't think that doctors see nurses as much as handmaidens as they have done perhaps in the past.... More and more now I do feel that doctors recognise that nurses are professionals in their own right and quite rightly. There are circumstances when they (doctors) recognise their own limitations and would give over the care to the district nurse.*

(Student district nurse)

For the student district nurses, being recognised as a professional by the medical practitioners; meant having autonomy over the care of a client, without the interference of doctors. This was viewed as a progression from the days when nurses served the doctors (see chapter 3). Later in my conversation with Frances, she appeared to contradict herself, by stating that there were times when district nurses were the '*dumping ground for what the GPs don't want to do!*' From this comment I deduced that in spite of the nurses' progression in terms of role, there were times she felt obliged to comply with the doctors in order to meet the needs of the client. However, this does not necessarily mean that the GP did not acknowledge the advanced roles of the district nurse, but that they were able to transfer more of their work to the district nurses.

Upon exploring the student district nurses, responses to how social workers viewed them, there were relatively few comments. However, my attention was drawn by the way they made references to their overall approach with clients and to their historic image. For example, Dot commented on how the district nurse was considered by the social worker as the caring and over-bearing mother figure.

Ex.1.7

Dot: (the social worker say we are) *sort of mothering.*

*They (social workers) say we interfere and we try and do too much for people!*

(District nurse student)

Notably, the involvement that the district nurses enjoyed may be viewed by social work students as 'interfering' and unhelpful. I explored this further later in the findings (p.121).

Ex.1.8

Peter: *I'm sure they (social workers) don't see district nurses as like these old time women that wear these silly hats and go out on the moors and we don't see social workers as hippies that wear sandals anymore - that's all gone!*

(District nurse student)

In contrast with Dot, Peter was concerned about the historic images and stereotypes, and therefore attempted to reassure me that these images had been dismantled. However, his raising of this issue and the apparent hesitation in his expression perhaps implies that he believes that the old stereotypes retain sufficient potency that they need to be challenged (see Appendix – reflexive notes 1).

At this point, before moving on to public perceptions I would like to add that when I asked the students to reflect upon what they thought of the other occupational group, there were few explicit comments from both student groups. Both groups were reluctant to make explicit the historic, stereotypical, image-related comments raised by Peter. Overall, the social work students felt they could not really comment on health workers or district nurses, because of their limited experience of working with them. The district nursing students, on the other hand, had more working experience and made general references to social working practice. For instance, there were comments like, '*risk takers*', '*more laid back*', '*fighting over costs*' and '*task orientated*'. It will become clearer what they thought of each other's occupation in the next section, where I examine their descriptions of how they defined each other's role and how they negotiated with each other in resolving issues concerning client care.

### **Public and client perceptions**

There were many references from both groups relating to how they were viewed by the public and their clients. Often students felt their public image, their authority, and how their roles had become interpreted were largely influenced by the media. From the analysis the emergent themes were strongly related to the visibility of their role, and it was this that I explored further.

### ***The invisible figure***

The social work students described how they were the silent workers and ghost like figures, because no one knows or understands what they do. Also, their '*successes are not*

*highlighted*'. These students pointed out that their roles only become visible when something goes wrong, or when they have to enforce an unfavourable legislative action, and then it is '*the social workers' fault!*' Therefore, they are seen by the public as someone who "*takes away other peoples children*" or in the eyes of the elderly, '*they (social workers) have come to put me in a home*'. For many people, the students believe that the social worker has become a threatening bogeyman, which they felt was reinforced by one-sided media coverage.

Ex.1.9

*Lynn: I think the media influences the public and there is a lot of bad press, there is never any good press about social workers.*

(Social work student)

I might add at the time of these interviews (2000-2001) it is likely that these feelings may have been heightened by the media exposure and public enquiry into a child death; following child abuse (Victoria Climbié- Lord Laming Enquiry, 2000). This particular case may have been in some of the students thinking, but was only explicitly raised in conversation by Ruth.

### ***Visible***

In contrast, the student district nurses described many of their roles as physical and visible in nature. Often the outcomes of their intervention were recognised and welcomed by the client.

Ex.1.10

Francis: *within district nursing you can see the outcomes you know sometimes very quickly. You know you can actually - umm heal a wound very quickly or you can help somebody to a nice death - if you understand what I'm saying, or you can make life easier for somebody by getting a piece of equipment.*

(District nurse student)

Therefore, they felt they had become known by the public as someone who will help them, make them feel better, and someone to be trusted or to tell them what to do.

Ex.1.11.

Sarah: *if you've got a patient who has struggled, an elderly couple and they have been struggling to manage at home, you can go in and make their life easier then, to them you are a little tin god.*

(District nurse student)

Ex.1.12

Sophie: *and they (patients) often ask us [nurses] things like, even if it is just 'Who do I go to?' 'Who should I ask about this?'*

(District nurse student)

A few of the student district nurses reflected in depth upon how their public acceptance and appreciation were linked with the uniform. Below is an example where the uniform became a recognisable, authoritative symbol that enabled the nurses to perform their tasks.

Ex.1.13

*Frances: When I wear the uniform I've got to admit its lovely - you're a nurse. Patients see you as God. What you say goes, you know, - or it appears that what you say goes. Umm- and they are very grateful, even for a minute amount of support or help you give. Because you're the NURSE!*

(District nurse student)

The above also suggests that through the uniform Frances enjoyed the power and the admiration from her clients. Frances went onto describe to me the difference she noticed in patient responses when she visited in her health visiting support role, where neither her role nor her identity was so easily recognisable or viewed as effective by the client.

Ex1.14

*Frances: I've got to say in the other (health visiting support) role - its not always as welcoming (by the client) -umm you can't always be seen as being effective - you might spend a lot of time there (with the client) and still not resolve issues and problems that might be apparent.*

(District nurse student)

Sophie's account illustrated a similar public response concerning the familiar image and role of a nurse; again the uniform played an important role. During the summer months her district nursing team changed their usual uniform to a polo shirt and shorts. When wearing the 'summer' uniform she found that she was treated with suspicion by the clients and was not given the same immediate access to the client's home.

Ex.1.15

*Sophie: It was very interesting, 'cos when I went to people I haven't been before, they (my clients) automatically stopped and looked at me (wearing the new summer uniform) as if to say 'Who are you?' Whereas, I would have walked in with me (usual) uniform.*

(District nurse student)

The district nurses' uniform appeared to play a significant role in how patients perceived recognised and understood the actions of the nurse. On the basis of how patients recognised the nurse, the district nurses were allowed access to their home. This symbol appears to serve the district nurses well, as a powerful, non-verbal negotiating tool that enables the nurses to perform their duties with little questioning from the client or public. However, it may be the uniform that perpetuates the past images of the district nurse as a bedside carer, or as Peter described, one of these 'old women that wear those silly hats' (Ex 1.8.p.118). I might add Peter may have felt very different to the other district nurse students in terms of the uniform, and how the nurses' image nurse may have enhanced or impinged on his working relationships, but this was not overtly discussed in the interview (see Appendix-reflexive notes1).

### **Authority**

From the above examples the practitioners highlighted the importance of visibility and how this influences public perceptions of their respective occupations. Equally, they believed that the type of authority the occupation has become associated with appears to influence how the public responds to their intervention. Overall, the district nurses felt

that the form of care they provided was largely welcomed and praised by their patients, and generally the patients readily accepted and obeyed their advice or instructions (Ex. 1.11, p.121). In the case of social work, it was known by the public that their authority was underpinned by legislation and therefore, the students felt their intentions were either treated with suspicion or as undesirable by their clients.

Ex1.16

*Miriam: Joe Bloggs (the public) shall we say, see social workers as all seeing, all-doing very powerful beings who can walk in and take away your children, because they (the public) think you can. Or you leave them because they (social workers) can't be bothered to do anything about it.*

(Social work student)

Ex1.17

*Ruth: You are just the student who's come into placement. You don't know the system. They [the client] still look at you, as an authority that is going to take their children away. It's not me who decides!*

(Social work student)

The social work students often felt that the association with such power led the client to believe they had the authority to provide certain services. Moreover, when the social worker was unable to fulfil the client's expectations or provide a particular service, it was perceived as personal, that *'they don't want to'*, rather than they were unable to. This was notable in my discussion with Lynn.

Ex1.18

Lynn: *When you are unable to give them what they want – you are the most horrible person in the world!*

(Social work student)

### **Regulatory Support**

For both student groups, the way they conducted themselves at work symbolised the mark of a professional. There were, however, noteworthy differences between the two groups in how their conduct was guided and monitored and this did relate to how supported some of the students felt in their work.

#### *i. Sense of belonging*

The district nursing students identified with a prescriptive set of guidelines and expectations, shaped by the regulatory bodies that belonged to their occupational group; notably, the United Kingdom Central Council for nursing, midwifery and health visiting (UKCC - now the NMC) and the Royal College of Nursing (RCN). For example, Sophie explained how the professional code of conduct guides both her thinking and actions towards her clients, as well as how strictly she adheres to them.

Ex1.19

Sophie: *knowing that there will be organisations around, professional bodies like the RCN and the UKCC that govern a lot of actions that you do. I think that gives you a professional identity because you know you do have codes of conduct and you do have rules and regulations. Having the profession in good standing and not bring disrepute and that sort of thing that is at the back of*

*your mind with any action that you do. You've always got to do it in a professional manner, an appropriate manner.*

(District nurse student)

Maintaining the reputation and upholding the values of the nursing profession is very important to Sophie as it gives her a sense of belonging and stability, through the provision of guidelines and common values.

## ***ii. Flexible guidelines***

In comparison with the district nurse students, the social work students viewed the British Association of Social Work (BASW) codes of conduct, as flexible and open to individual interpretation. This perceived flexibility created concerns for many of these students with regards to how they were going to perform their roles in practice. For instance, Ruth expressed this uncertainty and lack of clarity as she anticipated practicing as a qualified social worker.

Ex.1.20

*Ruth: Am I going to be able to do the right thing? What are you expected to do? What are the right decisions?*

(Social work student)

Likewise, Trish felt there was a lack of a prescriptive practice within social work and 'doing the right thing' was not obvious until 'something goes wrong'. From my conversation with Trish, I began to gain a sense of how unsupported she felt and how she thought that no one really cared about what the social worker did, unless there was a problem. She explains further,

Ex1.21

*Trish: Everybody is happy to let you bob along doing what they are doing, until something goes wrong and then obviously the person on the ground and who is doing the work, who's doing the job, who has the contacts, he's the person who gets the blame.*

(Social work student)

At first glance, it is possible to attribute the emerging concerns of the students to inexperience and anticipation, as they take up their new positions as qualified practitioners. However, there were wider implications that went beyond novice anxiety. Sandra informed me how difficult it was to enforce standards of care and professional accountability within social work because of the type of work they were involved with. She went on to explain that it was difficult 'to know' or to provide evidence that the appropriate action towards a client had been taken by a social worker.

Ex1.22

*Sandra: But how do you know? Who knows? I might do something very wrong which could cause someone to commit suicide, or it could have a serious effect for them to go and abuse somebody else. The client group you work with means you could use them as an excuse*

(Social work student)

The above examples seem to suggest that the students were looking for a known, standardized way of working. They appeared to stand alone in their decisions and their actions (See, Ruth Ex. 1.20.p.126), without the obvious collective support enjoyed by the nurses (Sophie Ex.1.9.p.120). However, it was only Sandra who seemed to be particularly

unhappy and concerned with this flexible way of working. She pointed out to me that without an enforceable, accountable and standardized practice both the client and social worker may be left feeling unprotected. As Sandra remarked above, the client is exposed to possible harm from the practitioners and the social worker may well be vulnerable to errors or criticism from others (Ex.1. 22. p.127).

## **2. Defining professional boundaries and roles**

Progressing further, I examined how the two occupational groups defined their boundaries and roles. In my quest to understand these practitioners, I sought to uncover any commonalities between the two occupations and to identify any areas where they felt their roles were unique.

### **Similar goals and tasks**

There were similarities between the two student groups with regard to their overall approach to the client. Both groups shared a keenness to remain client focused and to do the best they could for their client within their roles. Often in practice this involved assessing and coordinating care, making appropriate referrals to other practitioners, and managing support care to their clients.

Ex.1.23

*Lynn: the ideal is – a social worker for me, will be there for a person. To be able to give them as much support, whether that'll be physical, or to be put in contact with other people (other practitioners).*

(Social work student)

Ex.1.24

*Sophie: Well nursing is helping someone get washed and dressed all that part of their care- I would like to think it is looking after the whole person and looking after them holistically looking at what all their needs are and then referring to the most appropriate service.*

(District nurse student)

Although Sophie and Lynn are from differing disciplines, they both stressed the importance of meeting the needs of the ‘whole’ person – referring to the physical, emotional and social. They held similar understandings of the care of the person and suggested similar solutions to client need.

### **Professional differences**

In spite of the similarities, both student groups were quick to point out that their occupations were “*two very distinct professions*”. One student explained the differences,

Ex.1.25

*Peter: We have two different ideologies, different priorities of care and a different language.*

(District nurse student)

Moreover, the analysis revealed marked differences between the student groups in how they defined their roles and professional boundaries in terms of their contribution to client care, and how they delivered the service.

### **Contribution to client care**

Frances goes on to clarify that the interventions effected by district nurses like herself usually involve the physical aspect to nursing. Often actions they performed were in relation to the body, where outcomes were visible and achievable (See Ex.1.10. p.121). Generally, the district nurse students described their role in functional and task-orientated terms, and they appeared to have a prescriptive approach towards client care. Furthermore, Frances views the prescribed care as her responsibility; '*it is the nurse that manages the patient care*', she states, as if it was not a dual responsibility between the client and the practitioner.

In comparison to the district nurse students, the social work students emphasized how their role differed from that of the nurses and the medical profession. They talked in terms of values and how they challenged 'professional judgments' concerning their clients.

Ex.1.26.

*Sandra: We're the only profession that's talked about values and judgments – it's really interesting to see we are different. They (doctors and nurses) focus on health and well being of an individual and although they've (the doctors and nurses) facts around health, and scientific proven facts. However, they (the doctors and nurses) interpret those through their own personal values and judgments.*

(Social work student)

Interestingly, Sandra takes great delight in expressing their role differences and is quick to point out how health workers are blinded by their own personal viewpoints. However, from the overall tone of the above comment, it may be said that she too was unaware of how her own prejudices and interpretations may shape the way she construes clients and other practitioners.

The social work students also described their role as advocates, supporting, enabling and empowering the client, by providing education and *'the means to access services.'*

Furthermore, the social work students were particularly keen to emphasize how (in many cases) they encouraged the client to maintain some control over their own care, by involving them in some of the decisions over the form care should take. Therefore, a large part of the role involved listening to the client and providing emotional support in ways Lynn describes below.

Ex.1.27

*Lynn: I think a social worker is like a sounding board, somebody to be shouted at sometimes. Somebody to take your (the client's) frustrations. That's what a social worker is. To be there for emotional support as well.*

(Social work student)

### **Personal involvement**

There were differences between the two groups in terms of how and where they set their roles and personal boundaries with the client. This seemed to be associated with how the students construed the perceptions of the public. For example the social work students thought that the negative media and their legislative authority overshadowed their roles.

They believed that the public was uninformed with regard to their role, their actual authority and the support that they could give (pg.119-120.). Therefore to establish a rapport and to overcome misunderstandings between the client and themselves was a priority on their first encounter with the client. They did this by clearly defining their roles and their involvement.

Ex.1.28

*Trish: I think as long as they (the clients') are clear and you are clear of your roles, that is this is what you do and this is why you are here and this is why you are involved, and they (the clients) are clear*

(Social work student)

Overall, for the district nurse students negotiating roles with their clients was not a major issue or a source of concern. From the earlier examples, their general acceptance along with people's perceptions of the nurse, seemed to give them immediate unquestionable access to a person's home, even if clients were unsure why a nurse was visiting them (Ex.1.15, p.123).

### ***Intimacy***

Alongside this privileged admission to the home, the district nurse students described a permitted access to patients' personal boundaries, which is unique to nursing. I have identified this aspect of their care as personal intimacy. This intimacy is almost unavoidable and is permissible by the client. This is partly because of the type of care district nurses provide in the home and partly because this care is provided for long periods of time, for example, when treating leg ulcers. In the example below, Sophie not

only describes a physical intimacy but also an emotional involvement, which is avoided by the social worker students. This closeness is what Sophie likes about her work; for her it is what nursing is about, and the reason for her taking up the career.

Ex1.29

*Sophie: I was just impressed with - the relationships you can build with people and how close you can get. You could be visiting someone for months if not years at a time sometimes – umm and you do get very close to them –and I think that appeals to me. I think we often become friends to people because we are there long periods of time so I don't know if there is the same professional barrier that there would be.*

(District nurse student)

### ***Personal distance***

However, there are times even in nursing where a personal distance is considered appropriate. Earlier, I identified how the nurse's uniform allows entrance into people homes and enable the nurse to perform personal tasks (p.122). The example below demonstrates how in certain situations, the uniform can create the necessary distance between the nurse and the client.

Ex.1.30

*Sophie: I think the uniform can help in some ways, when we have younger people and I think having a uniform for them maybe does create that bit of a barrier. Especially, where they know actually she's here to do a job and yes it might be embarrassing for me, she's a professional so lets get on with it.*

*So it can take some sort of the embarrassment out of the situation. You are not just some young person coming to do something quite personal for them, just in everyday clothes and I think it does create that identity for them (the patient) and makes it a bit easier.*

(District nurse student)

Through the uniform Sophie becomes the professional nurse and represents all that is expected of her, and at the same time, she uses the uniform to help her form a visible barrier to protect herself, and the client from discomfort.

For the social work students it was vital to maintain a consistent personal distance between themselves and their client, in order to exercise their supportive or authoritative role. Examples given by these students, were cases where they may need 'to take away children' from their parents, or in other cases where they may need to remain impartial when dealing with sensitive family issues.

Ex.1.31

*Ruth: Social kind of values you don't get involved as much, well as much as you want to. You can get involved in helping, but there are certain issues you stand away from.*

(Social work student)

There was a consensus of opinion amongst the student social workers that 'getting emotionally involved' was not helpful or enabling for the client. All of the students spoke of standing aside or being objective in their approach to care.

Ex.1. 32

*Ruth. If they have got family problems you can help to get them together, you can't take sides and say, 'why did he treat you like that?'*

(Social work student)

Trish also emphasises the importance of keeping a personal distance between the clients she deals with. Furthermore, she went on to describe why she ensured there was a geographical distance from her work and home life.

Ex.1.33

*Trish: I think it were a conscious decision to not to work in my own local authority where I'm going especially, because it is child protection. I didn't want to be identified (by clients) on a Saturday when I'm shopping with me family.*

(Social work student)

With regard to the earlier analysis concerning the public perception of social workers and their legislative action, it is possible that being unnoticeable and invisible has its benefits. It is logical to deduce that the stance Trish takes towards the client gives her the sense of protection from discomfort as much as the uniform does for the nurse.

### **Response time**

From the analysis so far I have identified that the student groups perceived fundamental differences between their occupational groups in terms of their approach to care and involvement with the client. Therefore it is perhaps not surprising that they perceived their

priorities differently too. In particular, the district nursing students took pride in their prompt response to a need.

Ex.1.34

*Dot: The term urgent is very different to social services; we have response times. An urgent response is something like two hours. Whereas responses for say social services is days, working with that is very difficult because urgency doesn't exist. - (After a moments thought) It's only because our concept of urgency is different.*

(District nurse student)

Ex.1.35

*Sophie: If we get a referral in, we either act on the same day or within 24 hours hopefully, whereas a social worker, I know we did an urgent referral and underlined urgent six times and I think it was still a week and half later when they (social workers) actually went out to assess this person.*

(District nurse student)

There is an apparent immediacy to the role of the district nurse in contrast with the approach taken by social workers. This is perhaps to be expected as the nurse is concerned for the physical health, which may require prompt treatment for the safety of the client. For the social work students, response time did not appear to be a priority. They described their role as gaining a comprehensive view of the client's situation, mediating between the client, other professions and organizational processes. Often this process takes time and coupled with the flexible style of the social workers, may lead

some district nurses to regard them as slow, or '*laid back and not taking things seriously*'

(Dot: district nurse student).

The social work students did not mention response time when talking about their work.

This may be attributed to their lack of experience working with others or perhaps it was not considered as high on the list of their concerns.

### **Defining each other's roles**

In spite of all the students recognizing broad differences between their occupations they were very vague when it came to describing each other's roles and the other's approach to the client. Some of the student district nurses only had contact with home care assistants and home care managers rather than qualified social workers, which may have led to the following comments,

Ex: 1.36

*Peter: I see them providing all the social aspects of care that don't really fall under the health reins*

(District nurse student)

Ex.1.37

*Sarah: I think they look after more of the hygiene, financial issues.*

(District nurse student)

However, there was a tendency amongst all of the district nursing students to emphasize the financial aspects or organizational constraints upon the social workers' role.

Ex.1.38

Peter: *One's (social work) looking at finances and the other (district nursing) is looking at need really. We (district nurses) are looking at what the patients should have and they (Social Services) are looking at how much they can afford to give them, which is a different aspect.*

(District nurse student)

Likewise, some of the social work students were rather vague concerning the role of district nurses. The few comments made by social work students were in the context of their personal experiences, rather than their working or placement experiences.

Ex.1.39

Miriam: *I don't think you have enough contact to be able to say. An educated description of what it is that they do, I sort of see them as more medical type, making sure that there is no infections and they [patients] have the injections.*

(Social work student)

The social work students appeared to be aware of some of the tasks that district nurses may perform, but largely were unaware of how district nurses prioritize their care or how they work. This can be attributed largely to the lack of contact and experience of working with nurses; consequently they relied upon generalized stereotypes or 'educated' guesses.

### 3. Professional socialisation and learning experiences

From the issues raised concerning professional identity, many of the students appeared to have clear ideas about what was important to their occupational identity, whether it was values, their organisational body, or the type of responsibilities that held them distinct from others. This is reflected in how they defined their boundaries and roles with other professionals and their clients. Largely these ideas appear to have developed or have been shaped over time, and cannot be entirely attributed to their current training programme. For instance, the social work students went to great lengths describing their previous course experiences, how this was significant in leading them to their chosen career, and how their experience will help them in future situations.

Ex.1.40.

*Miriam: It (the social work course) is good preparation. I did come with a grounding, it was for me life experiences, particularly due to the fact I have a disability, I think that made my life experiences very varied and I'm involved in charity work and have been the past 9 years. I think that's what spurred me on to come onto this course.*

(Social work student)

The district nurse students, on the other hand, had already occupied a previous nursing role and were on the course to underpin their practical experience with theoretical knowledge, mainly as a vehicle for promotion. Sophie describes below where she has acquired her notions about being a district nurse and her approach to her practice.

Ex.1.41

*Sophie: I think the appropriateness (of conduct) again comes from role*

*models as much as anything, seeing how other people act and if you think that was appropriate and maybe adopting that.*

(District nurse student)

An earlier example from Sophie (Ex.1.19. p. 125) highlighted how she has come to know what is expected from her through the professional bodies and organisations, such as, the UKCC and RCN. She demonstrates how working experiences and active engagement with others can shape or strengthen her ideas about her practice. This appears particularly important if the engagement is with a senior practitioner whom the student respects. For instance, Trish's example below is interesting in how her placement supervisor influenced her views concerning how others valued her occupation. In this situation Trish was with her supervisor, observing a social worker in a courtroom case.

Ex.1. 42

*Trish: I went to court with my work placement supervisor and she said just watch, it's quite interesting when we go into courtroom with the doctors and the barristers. The social worker is the bottom of the pile really.*

(Social work student)

The supervisor raises Trish's awareness to their status within the courtroom, in terms of how other professionals talk down to the social worker in the courtroom and how their contribution to a case is unrecognized. Trish then recounts other instances of where social work went unrecognized. It is possible to see from Trish's experience how tutors and other social workers may perpetuate the feelings in students that they are an 'unrecognized' profession.

### **Course experience and placement**

A majority of the students felt positive towards their course experience in terms of content and felt it had given them a good base knowledge and valuable insights into their chosen career. Many of the students went so far as to share how the course had impacted upon their practice, their current understanding of organisational structures, and their personal lives. However my interests here were towards the ways their student training and placement experiences constructed their ideas about their identity in relation to joint working. Also, whether the students thought their training had prepared them for joint working projects. It is to this I now turn.

### **Training with others**

At the undergraduate level there were few joint training experiences recalled by both student groups. For social work students, the presence or absence of these joint learning experiences largely depended upon the course pathway they had chosen; those who were pursuing a career with 'children and families' tended to undertake a 'Child Protection Module' where health visitors were often in attendance. However, this did not often give them the chance to intermingle with other professional backgrounds, nor share in depth differing ideas or experiences.

Ex.1.43

*Miriam: It's purely from a social work point of view. Health visitors will come into the equation at times, about their role and what their assessment might be*

(Social work student)

Other students appear to support the view that working together was mentioned but '*still they (tutors) don't do it on the course*'. What little experience of joint working the students had was mainly with voluntary agencies or in a social care environment. Therefore the overall impression was that the majority of the social work students had little experience of learning and working in a multidisciplinary situation with other professionals.

Ruth drew my attention to how the lack of inter-professional learning might shape a student's thinking.

Ex.1.44

*Ruth: It's really worrying. I still find that you may not even think that they (nurses) really matter you know as much. You do think that way (own job is more important than others) - you just centre yourself around your job and you just think about social.*

(Social work student)

Ruth appeared to be aware of the dangers of being preoccupied with her own course, thereby becoming narrowly focused to the point that she did not acknowledge or consider the possibility of other practitioners who could be involved in a client's situation.

In contrast, all of the district nurse students had worked alongside other professional groups at some stage in their career, and a few students had some training with other practitioners. However, experiences amongst these students differed according to the practice or the NHS Trust the students worked within. For instance, Peter and Sarah had a

number of multidisciplinary training experiences, as they had attended a few 'in-house' courses within their local Healthcare Trust. Sophie however, had made arrangements to 'shadow' a social worker within the authority in which she was based. This was a personal initiative in order to familiarize herself with the local social workers.

As part of the district nursing course at the university, students were expected to attend a 'collaborative module'. This gave district nursing students a theoretical underpinning to collaborative working, with lectures given by speakers from differing disciplines. In spite of these measures, the module lacked students from other professional perspectives. Also, the students informed me that they tended to socialise within their own occupational groups.

### *Suggested improvements*

Although there were differing levels of experiences within both student groups, there was a willingness amongst all of the students to have shared learning experiences. A few of the students felt it was important to have the opportunity to mix with other professional students early in their training, where they could develop a greater understanding of each others roles. Suggestions made by district nurse students included generic training or joint foundational courses. In particular Peter argued that it would be at undergraduate level (RGN) where *'you could dispel a lot of the myths and a lot of the ideologies'* between the two occupations.

These ideas appeared to be supported by social work students who had experiences of joint education with Health Visitors on a 'Child Protection' module. However, these students argued that their learning experience did not go far enough to 'break down the barriers' or dispel myths between the different professions. Lynn suggested that a similar knowledge base in some areas would facilitate professionals in working together and would prevent any domination or superior attitudes of one profession over another.

Ex.1.45

*Lynn: Because you have done the training together there is not going to be that – 'oh I'm a health worker you know' – 'oh I'm the social worker'. If we had the same generic training, or something where we all came up together, we would have the same ideology and therefore it would be a more seamless approach.*

(Social work student)

However, Lynn's solution appears to be incongruent with the earlier analysis, as both student groups took great delight in sharing with me the differences that they felt there were between the occupations. Notably Sandra and Peter felt it was their ideology and values that made them unique (Ex. 1.25, p.129 and Ex. 1.26, p.130) and different from each other. Also, it was Peter who wanted to move away from generic working in order to specialise in district nursing (see p.94).

#### **4. Beliefs about joint working**

In this section I will examine how the students defined joint working and in doing so, revealed how they felt integrated care worked in practice. Through discussing the strengths and weaknesses of joint working the students identified the hindrances to joint working practice and how this affected the meanings they attached to their roles and professional identity. Also they offered suggestions as to how they might improve their relationships with other practitioners.

##### **Definition of joint working**

Upon asking how the students defined joint working, there were a variety of responses. All of the students viewed joint working as a good idea and felt it could benefit the client. For Dot (district nursing student), joint working was a philosophy that should be practised throughout the different levels of the organisations.

Ex.1.46

*Dot: I think if it comes from the whole right from the top, actually planning how you spend the money to start with, joint committees, decision-making, right the way through to the various groups*

(District nurse student)

On the other hand Peter (district nursing student) and Sandra (social work student) emphasised the goals of joint working practised at operational level.

Ex1.47

*Peter: Joint working is when we all work together to provide this seamless*

*care, but we don't.*

(District nurse student)

Ex.1.48

*Sandra: The legislation says the welfare for the whichever client group you are working for is paramount and especially children and you are all working to the same goal which is the idealistic message, in reality we are not all working to the same goal*

(Social work student)

The examples quoted above implied that the students were well versed in what joint working practice should be, in what was expected of them, and that joint working was politically encouraged. Some of the students gave examples of when joint working went well, but there were times when it was not what they were experiencing. There appeared to be a chasm between the joint working philosophy and practice experience. As in the experience of Ruth (social work student), it was a case of '*we (social workers) do our bit and they (nurses) do their bit*'. It might be argued that many situations do not require the face-to-face meeting or joint visiting of practitioners, because the practitioners are confident that once a client is referred, the other party is doing '*their bit*'. On the contrary, all of the students felt that in many cases joint working and inter-professional relations were unsatisfactory and that there was need for improvement as exemplified in the above. Also, district nurses and social work students talked about '*gaps*' in care where patients did not receive the appropriate continuation of their care when they were referred from one service to another. This leads me to the next section where many of the students went on to describe some of the reasons for the problems they had encountered,

and how they would overcome some of these difficulties. I have summarised these below as *Resource differences*, *Who does what?* and *Relationships*.

### **Hindrances to joint working**

#### ***Resource differences***

Both student groups identified organisational characteristics which either enhanced or hindered their service provision. In particular, there were considerable resource differences between the two organisations in terms of what funds were available, how they were funded, and the process of obtaining resources. These issues were largely taken up by the district nurse students.

Ex.1.49

*Dot: Some things are very now if you have got someone who is disabled and 'they've gone off their legs' and need equipment in... For health, if I ring in the morning before eleven o'clock I can have a commode in that bed that afternoon. Whereas if it goes on social services budget, it can take a week so although they are very good and if its an emergency we (the health side) can do it.*

(District nurse student)

Often the district nurses felt the responsibility to 'pick up' or 'fill the gaps' where social workers were unable or slower to provide particular care (see earlier example regarding response times, p.135). Therefore 'who does what' in a joint working event was thought by some of the district nurse students as ultimately down to resources and who pays for the care.

The concern over who pays for the care appeared to be linked to the NHS Community Care Act (1990). The Act stipulated that certain aspects of personal care could be provided by social services. However in practice, if care were supplied by social services, the client would be expected to financially contribute towards the care. If a nurse provided personal care, the care would not be charged to the client. Consequently, when there was a lack of resource either from the social services or the client, the nurses felt obliged to supply the service. At times this was a source of friction between the two services as highlighted in Peter's example.

Ex.1.50

*Peter: The end of the financial budget social workers try and dump it all on you. Cos' we (health) are free and they (social services) charge.*

(District nurse student)

Although the district nurse students were aware of their own budget limitations, they felt their role and service provision was not so organizationally and financially constrained as social services.

The social work students supported these views, and because of these financial constraints they often felt there was a conflict between the professional values they were taught and the organization they worked for. Often they described themselves as having '*their hands tied*', or having to '*fight the system*' in order to meet the needs of the client.

Ex.1.51

*Miriam: In my case looking at children, I can have a good guess at what's*

*going to be good for them but can't get it. Funds, bureaucracy, red tape.*

(Social work student)

***Who does what?***

Since the devolvement of personal care to social services, there were roles that some of the student district nurses considered as no longer part of their nursing duties, such as, personal hygiene and the giving of medication. However, there were times that social care services did not agree with the district nurses concerning what was a nursing care task and what was a social care task. Peter explains the problem.

Ex.1.52

*Peter: Putting emulsion cream on legs you have carers going in supplied by social services and yet, unless it's on their social service package they won't apply the emulsion to the leg. They will say 'no it's a nursing job!', because its cream, and we say, 'why, if it's a carer we would expect them to do it you know, husband and wife'. Medications, they (social services) expect us to do it. We say it's not our role!*

(District nurse student)

Some of the district nurses argued quite strongly that the hygiene care as described above did not require nursing intervention if the person did not have a medical problem. However, discussions with other district nurse students appear to contradict Peter's viewpoint; it would appear that they would like to be involved with basic nursing care (Ex.1.24. p.129). Nevertheless, defining who does what remains a problem between the two services, and as the students argued, could create gaps in the service provision.

## Communication and Relationships

Many students described a type of joint working practice that took the form of working alongside, either in parallel or sequential to, other professional groups; for instance, joint working would involve referring and delegating work from one service to another. Often these negotiations between district nurses and social workers were made over the telephone or through answer machines, with little face-to-face contact. There was a consensus of opinion amongst all of the students that meeting with the other practitioners would improve relationships and negotiations. Sandra (social work student) described a situation where joint working went exceptionally well, as over time different disciplines met together, shared information, shared a common goal and developed a level of mutual trust and 'openness'.

Ex.1.53

*Sandra: Nobody in the group had their own agenda, nobody in the group felt worried that any other member of the team was actually taking over. Information was shared honestly and openly without fear that somebody would use information in a negative way. It worked well because everybody wanted the best for the client group; nobody had their own agenda to want more for their particular little bit (for their service). It was open sharing and the meetings were very good. (Later) They (the managers) had worked together for a long, long time and the workers and the managers hadn't left so they got to know each other very well. The rapport between each manager was very good!*

(Social work student)

In contrast Sarah (district nurse student) highlighted the problems when there were no effective communications and relationships between practitioners and carers of a client. In one situation she described how home care assistants had failed to alert her, when equipment that facilitated in preventing pressure sores of a bedridden client had failed to function. When Sarah raised the issue of communication, the home care assistants replied defensively by saying it was not their responsibility. Sarah was convinced that if they had met and developed a relationship then the home care assistants would have felt at ease ringing the district nurses.

It was difficult for some of the students to imagine how they could overcome the hurdle of poor communication and relationships, as time factors and work load gave them little opportunity to meet others. Ruth took up this issue during the interview.

Ex.1. 54

*Ruth: There's not enough time for people to get to know each other. There is not enough time to view the trusting relationship, to look at somebody, all right, she is a health visitor, she has specialities as important as mine.*

(Social work student)

One solution offered by one district nurse student was to have the social care services working on the same site as health workers, to enable them to get to know each other.

Ex.1. 55

*Dot: Where social workers have been based with GPs and the team in surgery. You can have a appreciation of where they are coming from as well*

*if you actually see them day to day working with you, it helps to break down barriers.*

(District nurse student)

This view was supported by Peter who emphasised that through developing informal face-to-face relationships, the different services would be mutually informed when providing joint care to a client.

Ex.1. 56

*Peter: If we all worked alongside each other and we all learnt to speak each other's language, it will become very much easier to pass information and you know, casually drop information. Whereas now it is quite formalized way of communicating with each other.*

(District nurse student)

### **Impact of joint working on professional identity and roles**

I mentioned in the literature review how collaborative working may encounter resistance or caution from some practitioners, in terms of how they perceive their roles and the meanings they might attach to their roles. I have included two interlinking concerns here that emerged from the analysis where students identified a potential *loss of role* and loss of *image* as a result of a client's re-construal of the caring professional's identity.

#### ***i. Loss of role***

It may be assumed that Peter welcomed the opportunity to devolve some of the basic hygiene roles to social services and care workers (see Ex.1.52. p.149). However, there

were other students who explicitly expressed their reluctance to leave aspects of nursing care behind or share them with other services. Earlier, Sophie described an intimacy and involvement, which she enjoyed with her clients. Dot viewed social care workers as 'taking over increasingly basic care', and how she would like to have more input. Therefore, it can be deduced that in practice these students may be reluctant to hand over personal care to social care workers. Sharing for the district nurse students may mean a loss of specialization and a loss of what it may mean for them to be a district nurse, whether it be the close involvement with the client or the sense of authority they exert. These concerns of *losing* their role were also shared by at least one of the social work students. Given that social work was considered a low political priority, and under-resourced, Sandra (social work student) feared that sharing for some practitioners may mean a loss of their job as well as their role.

Ex.1.57

*Sandra: I think fear of wanting to share because if we (social workers) share we might lose some of our professionalism. We might lose our role in this altogether, may be it's boiling down to an individual might lose their job because it is going to save money.*

(Social work student)

## *ii. Loss of image*

Some of the difficulties in joint working encountered by the district nurse students related to how the nurse was stereotyped as the bedside carer. I had identified earlier how certain actions and strong visual images had a lasting influence upon how the public and client viewed the district nurse. At times these lasting impressions appeared unhelpful in the

work of the district nurse, especially when roles change or when other professionals are involved in the care of a client. Sophie gave an example when she visited a client who thought that the nurse had called earlier.

Ex.1.58

*Sophie: 'Oh the nurse has just been' and they actually meant the home care. Whether that is a throw back to when nurses used to come and help with hygiene and things like that and they just used to it being a nurse, or they just call them nurse, or whether it is just someone coming to help them so they'll be the nurse.*

(District nurse student)

Sophie felt that the changes in their role and the involvement of many other practitioners in the home may create confusion amongst some of her elderly patients. Also, she pointed out how some patients had overcome this problem by naming the different practitioners according to their tasks.

Ex.1.59

*Sophie: 'oh yes you're (district nurse) the leg lady, the other one is the meal lady, and the other one is the getting dressed lady'*

(District nurse student)

Earlier I had identified how the district nurse students enjoyed their recognizable image, and how clients would know their actions and were praised by the public. Perhaps then joint working may mean for some a loss of public image, where they would no longer be recognizable and valued by their clients, but would become just another co-worker- a 'leg lady'.

## **Discussion**

The traditional notion of professional identity suggests membership of an occupational body that is characterized by shared fixed goals, stable qualities, and independence of action. (Freidson,1983, Freidson, 2001). In this study, the term ‘professional’ was often described by the students as a way, or a manner in which they conducted their work. This ‘sense of being’ was an active process of social engagement with other professionals and their clients; acting out of their knowledge, but also having this knowledge and expertise recognised and valued by others. To present this discussion I will first outline the contextual and personal influences upon professional identity construction. Then I will explore in detail the key elements of professional identity that emerged from the data. Finally, I will examine how a constructivist phenomenological perspective can further enhance our understanding of professional identity in joint working, by drawing upon Kelly’s sociality corollary.

### **Historic and cultural influences on professional identity**

The previous chapter highlighted the historic and cultural influences in the development of nursing and social care, and argued how these influences may have lasting and constraining effects upon professional identity construction. In support of the literature, my research findings suggest that public perceptions, and expectations of other practitioners, may exert pressures upon care professionals where they may not feel free to reconstruct or recreate their identities (Biggs, 1997). As was shown in the analysis, some of the students performed roles they no longer felt they identified with, partly because they were expected to perform that role and partly to achieve their professional values and goals. For instance,

the district nurse students found that the historic notions of the nurse as the '*handmaiden*' to the doctor, lingered in some general practices. In such cases district nurses were obliged to comply with the demands of the doctor in order to ensure clients received care (Ex.1.6. p117). Furthermore, the findings revealed the importance of the nurse's uniform and how in some situations this may perpetuate the historic public perceptions and media images of the nurturant carer. Hence, the uniform is a symbol that some nurses may be reluctant to leave behind because of the associated authority and image this evokes in the public (Ex.1.13. p.122).

The social work students felt that the media had encouraged the 'low' public opinion concerning their occupation. In one sense, they appeared to accept these poor evaluations as something that went with the job. However, at the same time there was an apparent determination in their fieldwork to cut through public misunderstandings by establishing a good rapport with their clients and to ensure good relations with other practitioners at operational level.

Concerning the impact of organisational constraints upon professional roles, it was the student social workers that particularly felt the constraints of their organisation – the Local Authority. There were times when these students experienced a sense of powerlessness in helping their client because of lack of resources and finances. Moreover, these students appeared to work in an ambiguous and fluid environment between the organisation and service user, where they had to adapt and modify their roles according to the demands of

the situation. In this way the roles of the social work students appeared less fixed and identifiable than the district nurses.

It is likely that there were financial and bureaucratic constraints within the NHS at the time of the study. Interestingly, the district nurse students did not raise these issues and were less critical about their organisation than the social work students. Their frustrations were often about supporting the short falls in care for social services (Ex.1.50. p.148). However, I suggest that this lack of criticism by the district nurse students, might say something about how they view their professional identity and how they are socialised. For instance, district nurse students are more likely to accept their financial constraints than social workers because they see this as part of being a professional district nurse.

Despite these contextual influences and organisational constraints, my constructivist phenomenological position argues that people are in action with social forces rather than subjected to them (Mair, 1979, Butt, 1998). Furthermore, meaning is created in the dialectic, described as the back and forth relationships between the self and the other (Spurling, 1977). In so doing, people shape their roles and relationships in a creative way that supports their personal constructs, reflecting individual meanings and experiences (Kelly, 1955). Applying this principle to my findings, it can be logically deduced that nurses may perform roles because they felt obliged to, but also because it supports their notion of what it means to be a nurse. For example, the physical, 'hands on', caring aspect of the nurse's role was essential for some of the district nurse students. They expressed this in the way they like to be involved and develop close relationships with their clients. However, this position raises some interesting questions concerning meaning and identity.

In particular, in what way do public and professional evaluations shape the meanings of practitioners' professional identity, and how essential is this recognition from others to their professional identity? I will return to this later in the discussion.

### **Key aspects to Professional Identity**

Moving on, it is evident from the analysis that the roles and the relationships surrounding practitioners are complex. Also, it is acknowledged there are personal differences in how professional identities are expressed and interpreted, reflecting variation in experiences and circumstances. However, amongst the student groups the study identified key characteristics attached to the concept of professional identity. These were a sense of belonging and support, recognition and value.

A sense of belonging and support within the occupation was a theme that emerged from both student groups. Sophie had recounted how her sense of belonging and support was underpinned by the shared common values and practices regulated and standardised by the professional body - the Royal College of Nursing (nurse union) and the UKCC (Ex.1.19. p.125). In contrast, the social work students did not seem to experience the same level of collective and regulatory support enjoyed by the district nurses. This presented difficulties for the social work students, in terms of uncertainty of what was expected of them and how to practice as a social worker. They appeared to stand alone in their decisions and actions, without the obvious support received by the district nurse students. Nevertheless, they identified with a collective set of values, and perhaps would be loathed to relinquish the flexibility and freedom currently associated with their work.

Another important theme was the extent to which the students felt they were recognised and valued by other professions and the public. Even those students who did not place an importance upon professional status desired their occupation to be recognised by others as making a valid contribution to care. For the social work students there was a consensus of opinion that their 'good' work went largely unrecognised, overshadowed by negative media coverage and public perceptions of their legislative powers. In contrast, the district nurse students had gained over the years a favourable public image and felt their roles had become known by the public and other practitioners in the community. Linked with the theme of recognition and value is the notion of visibility. I shall now explore this concept further.

### **Visibility of role**

I have defined visibility as where the roles and the attributes of a particular occupational group are seen and acknowledged by other practitioners, the public and their clients. Earlier authors have identified district nurse roles as '*invisible mending when it is done well*' as it is work that '*is out of sight and in patient homes*' (Goodman, 2000, p.107). On the contrary, the student district nurses described the positive outcome of their work as not only visible to them, but also as largely recognisable and visible to others (see example). Furthermore, the uniform enhanced the visibility of the district nurse's role. A few of the students described an expectation when the patients and public saw the uniform. Often these expectations were associated with the caring role of the nurse and therefore, patients would allow nurses unquestioning access into their homes.

In contrast it was the social work students who shared similar sentiments to Goodman (2000). Generally, they felt that their work was unseen, and was only made visible when things went wrong. From the analysis the following disadvantages of invisibility were identified. First, the social work students' felt their potential expertise was overlooked by other practitioners, leading to them being excluded from case decisions or contributing to client care. Second, with regard to distributing resources or funding their work, the social work students felt the government overlooked social services in favour of the health service (Ex.1.3. p.115).

There were times when being invisible gave some practitioners protection or the desired distance from their clients. For instance, there were times the students described how sometimes they did not want to be recognised, so that they would be able to carry out some of their 'child protection' roles, or enforce their legislative authority, with less personal hassle.

### **Anticipating events**

From my constructivist phenomenological position, visibility appears to play an important role in the intentionality and the anticipation of events. Where a profession lacks a visible role or a recognisable identity it may be difficult for other practitioners to anticipate their actions and work effectively with them in a joint working event. For instance, social work students explained that a lot of their work was hidden, or that they were identified with such a comprehensive label, that it was difficult for others to know and understand what they did.

Furthermore, Butt (1998) asserts that anticipation and intentions are expressed in our bodily posture, gestures and stance. These in turn are interpreted and responded to in the form of 'a social dance'. This is best demonstrated with the symbol of the nurse's uniform. The uniform displays a visible intention towards the client group that is associated with caring and helping. The client acknowledges the district nurse by allowing access to their home and the nurse in turn responds to the client's need. What happens then when intentions and expectations are unclear or ambiguous? The social work students within this study described situations where they were uncertain what was expected from them and were unsure of the 'right way to act'. Moreover they had felt their guidelines from their regulatory body were unclear and open to interpretation. Does this affect their *social dance* when working with other practitioners or with their clients? It is reasonable to conclude that where individuals are unsure of their professional identity and roles, their bodily stance and gestures may be misleading or misinterpreted by others involved in the caring event. Also it follows that where communication between people is over the telephone, through answer machines and nursing notes, the gestures (and body language) that support meanings are different and therefore, the 'social dance' between practitioners may be restricted or misleading.

### **Understanding others in joint working**

Many of the students from this study highlighted that they lacked understanding of other practitioner roles and perspectives. Those who claimed to have a 'growing understanding' only did so in terms of fulfilling their occupational roles and priorities. For instance, the analysis revealed that the district nurse students described social

workers as general providers of care that *'don't fall under the health reins'*, whereas the social work students viewed themselves as *'advocates'*, not solely coordinators of care. There was a failure in both student groups to appreciate and validate each other's perspectives. This is particularly demonstrated in the different occupational approaches when responding to a referral. For example, a speedy response to a referral was an essential part of the nurse's role, where promptness may determine either the safety or the demise of an individual. From the district nurses' perspective the social worker's comparatively slow response was due to financial constraints. However, the district nurse students had failed to fully appreciate how social workers generally construe their work, and that quick decisions may be inappropriate for long-term chronic social problems. The findings here suggest that in order for closer relationships to develop between diverse disciplines, it is necessary that practitioners recognise and validate the way each other construes their contribution to care.

By drawing upon Kelly's sociality corollary we can gain further insight into how practitioners may begin to understand how others construe roles in a joint working situation. As I described in the previous chapter, sociality is a working together by placing oneself in the other's position (Kelly, 1969). This is not just a cognitive appraisal of the other's role, but as Butt (1998) argues, sociality invites the other to express their perspective. Does this mean that in order for different professions to work together and communicate effectively each interaction has to be clearly and consciously thought out? This may be so when planning a joint working strategy, but what about day-to-day communication between practitioners at operational level? I referred earlier

to a '*social dance*' that takes place between people, where language and interpretation is expressed in action. The difficulty lies in the fact that many of our actions are pre-reflective and are not necessarily brought to our awareness until after the event (Merleau Ponty, 1962), or unless they are problematic. So how can student practitioners be encouraged to reflect upon their relationships and roles and effectively communicate their perspectives to others? One solution is to give them an opportunity to explore the ways other disciplines construe their identity and relationships within their training programmes.

The literature highlights how many health and social educators recognise the need for an integrated learning programme. However, it is hotly debated over at what point in professional training this would be beneficial for students. Earlier authors argue for a separate, foundational, professional education in health and social care, in order to ensure that students become firmly established in their occupational roles and values (Miller, Freeman, and Ross, 2001). The findings here suggest that, an over-emphasis of one world view and the lack of integration with other students at foundational level may not adequately prepare the student to engage with the multidisciplinary world. Without this experience of interdisciplinary interaction throughout their training it is argued that students are not in a position to either validate other perspectives or review their own identity and roles.

However, integrated training or shared learning alone will do little to encourage students to appreciate another way of seeing. Ideally, collaborative education would

maintain some diversity between the groups as well as some sense of commonality across the student groups. For example the current focus upon client needs rather than professional needs, encourages common goals and values across the occupational groups. The different ways the disciplines can contribute to care offers the diversity that the students so desire (as seen in our earlier examples). Furthermore, if we are to apply the principles of sociality to shared learning experiences, educators will need to explore creative ways of interaction between the two student groups. In this way the students may learn to reconstruct their identity and roles and reflect upon the roles of other practitioners.

## **Conclusion**

The student study has raised some interesting issues surrounding the concepts of professional identity, notably the importance of recognition and value. This is not in terms of comparing their societal position with others, but this was in terms of how other's valued and recognised the practitioners' contribution to client care. How professionals recognise and respect each other's contribution draws upon the concept of sociality. Here social interaction is vital, where practitioners learn to explore how others construe their identity and their participation in a joint working situation. On the one hand, many of the social work students interviewed were unsure of their relationships and roles because they lacked the opportunity and experience of working with other disciplines. The district nurse students, on the other hand, had multidisciplinary experience but remained unaware of the social workers' perspective on care. This is possibly due to the fact that many of the social workers' roles are 'hidden'. So then, who

should be responsible for raising the awareness of the roles of social workers, or of any practitioner for that matter? The answer to this question is that it is necessary for the educators to take some responsibility for improving ways that students may learn from each other as well with each other. Also, it is the responsibility of the individual practitioner to ensure that other practitioners understand their roles and at the same time attempt to understand the different roles played by other practitioners. Therefore, it is necessary for the organisations that employ care professionals to provide time for them to develop this sense of sociality; either during an induction programme, or through organised, multi-professional workshops.

I identified earlier that the constructivist phenomenological approach to these findings does raise questions, which led to the development of the second part of this thesis. I described how professional identities develop in action with others, and therefore are open to a degree of change providing this supports their personal constructs. Therefore what happens in situations, such as a developing service, where our identities and roles are challenged? How willing are practitioners to reconstruct their professional identities, and what conditions facilitate role transitions in a working environment?

My findings were gathered from social work and district nurse students and my interviews took place in an university setting, where perhaps joint working and collaborative principles are consciously raised as part of their education. Therefore a study investigating a developing service may give the opportunity to approach such

questions, and to explore how district nurses and social workers construe these developments, in terms of their roles, relationships, and professional identities.

## **Chapter 7.**

### **Study Two: The development of an out of hours district nursing service.**

#### **Part one: Introduction and methodology**

The first study gave me an insight into the notions of student social workers and district nurses, about how they identified themselves within their future occupational roles and their working relationships with other practitioners. Examining the way students construe joint working has highlighted how professional identity is challenged and negotiated whilst in action with other professionals. However, the students described occasions where they did not feel free to reconstruct their professional identity. For instance the district nurse students described how expectations from other practitioners and their patients exerted pressure upon them to conform to past stereotypical images. Some students also described situations where changes to their professional roles and image did not necessarily support their personal constructs of what it meant for them to be a social worker or a nurse. My desire to explore these issues further has led me to the study of qualified district nurses and social care work practitioners who have experience of joint working in the community. This chapter describes the background and the methodology. The findings and discussion are placed in the following chapter.

The study of joint working practice between district nurses and social workers led me to a particular community where there were many developments taking place. At the time this was not unusual as there were many organisational changes taking place nationally, as a result of the government's modernisation programme for health and social services

(DOH 1997, 2000). I anticipated that by examining joint working amidst other service changes, issues and tensions around professional identity and relationships would be brought to the fore. In particular, practitioners would have to reconsider their existing professional relationships and they would have to negotiate these along with the new policies and organisational changes that were taking place (Pietrioni and Pietrioni, 1996). My overall aims for this study are summarised below.

### **Summary of aims**

- i. To explore how district nurses and social care workers construct their identities within joint working situations
- ii. To examine how they negotiated their professional identity as a result of local and national organizational changes and service developments

### **Background to the study**

This second study took place between January 2000 and November 2001, at a time when Spilsdale's<sup>1</sup> district nursing service was extending its provision to a 24 hour service and the local home care team were planning an out of hours service. Consequently, the nursing and social care services were considering joint working strategies for when they launched their respective 'new' services. This was an important opportunity for me as a researcher not only to explore existing relationships between these two services, but also to observe the progress of their joint working relationships as they developed their services. Before I proceed further, I shall give a brief account describing the context of

---

<sup>1</sup> All place names and personal identifiers have been replaced with pseudonyms

these service developments within the area that they serve and a background of how they structure their provision at operational level.

### **Geography**

The development of the out of hours district nursing service (OHDNS) took place within the borough of Spilsdale, Northwest England. At the centre of this borough is the largest town, Wigglesworth, an industrial town that accounts for almost half Spilsdale's population of 198,000 inhabitants. The rural west of the borough consists of small communities, separated by steep valleys, containing the small towns of Honsley and Rossington. The eastern area of Spilsdale is known as the lower valley and contains the small communities of Mistlethwaite, Craigley and Tidvale. At the time of the study, Spilsdale NHS Trust provided services for the same areas as the home care services for adult care, supplied by the social services department of Spilsdale Metropolitan Borough Council. For administration of health and home care services, these areas are divided into Upper Valley, Lower Valley, and Central Spilsdale.

### **District Nursing Team**

The district nursing service consists of nineteen teams serving the Upper and Lower Valleys and Central Spilsdale. Each team has a caseload of patients registered on a GP list and is supervised by a district nurse team coordinator. The teams comprise qualified district nurses who have undergone 'specialist community' training; community staff nurses who have undergone a statutory nurse level 1 training; and health care assistants

who have no registered nursing qualification. Referrals to the service are usually made through other health and social service professionals.

The aim of the district nursing service is to provide appropriate skilled nursing according to patient and carer need, in order to maintain support at home whenever possible. Prior to the launch of the extended service the district nurses provided this care seven days a week between the hours of 8.30am and 11pm. Since the NHS Community Care Act (DOH 1990) a number of their previous responsibilities have been devolved to the social care services. These are aspects of care termed as personal hygiene, such as toileting and washing.

### **Social service care teams**

The social service teams provide care for vulnerable adults and children. For the purpose of this thesis I will focus upon the provision of elderly care services, where the boundaries of district and social service care often blur. Since the teams include a mixture of qualified social work practitioners and workers who do not hold professional qualifications, I shall refer to these practitioners as social care workers or social care teams.

The overall aim of this service is to provide services in order to maintain elderly and vulnerable people within their own home. Since the implementation of the NHS Community Care Act (1990), the services for adult and elderly care are provided and supported by two types of teams; the social care assessment team and the home care

team. The social care assessment team comprises senior practitioners and social care assessors who hold a professional health or a social work qualification. The home care team consists of home care managers, social care co-ordinators and home care assistants. Many of these practitioners and assistants do not hold professional qualifications, but have received in-house education and training.

The assessment teams carry out the initial assessments to identify social care need and design the care plan for the clients. Within Spilsdale there are four locality assessment teams plus a hospital team at the Royal United Spilsdale (RUS). These are Upper Valley, Lower Valley, North Spilsdale and South Spilsdale. Referrals to the assessment teams were made by the public, health and social professionals.

Once the client's needs are identified and a care plan is designed, the client is then referred to the home care teams, who provide home care services. The form of care provided varies according to individual need, but generally involves domestic, social and personal care. At the time of this project, the home care service was co-terminous with the district nursing service and was divided into three teams located within the three areas of Spilsdale. This service was available five days a week from the hours of 8.30am to 5pm, and was about to be extended to 11pm.

## **Methodology**

There were two goals for this study. First I wanted to gain an overall picture of the way the district nursing service developed amidst organizational change. Therefore, I decided to draw upon elements of story-telling techniques (Musson, 1998, Gabriel, 1998). This entailed conducting individual and group interviews of district nurses and social care workers at different points in the development of the service, supplemented with in-house documents and circulars. These accounts were merged to present an overall historic account of the development of the service. Second, I wanted to gain a sense of how the practitioners construed the changes that they were experiencing and how they negotiated their roles amidst the service developments. Hence, I subjected the data (gained from the individual and group interviews) to an in-depth template analysis as described in the previous chapter.

### **Data collection**

The data were collected in two stages over an eighteen-month period. First, during the planning stage of the extended service, data were collected during the period from May to August 2000. The second stage of data collection occurred six months later following the launch of the service, over the period of January to March 2001. My data collecting strategies were to interview key informants and then focus groups. Information concerning the service and the locality was gathered from in-house journals and local Spilsdale Health pamphlets.

## **1. Key informant interviewing**

Key informant interviewing is utilized by ethnographers as an efficient method in gaining insight into cultures and gathering information, which may be unavailable to those outside an organization (Gilchrist and Williams, 1999). At the time of the study I was working within a university setting, outside the health and social organization. Therefore, I needed access to the health and social staff groups, and 'inside' knowledge to update me on the current developments, practices and local policies of the NHS Trust.

To understand the development of these services I selected two main key informants who had specific specialist knowledge of the health and social services and the community services. They were the district nurse out of hours co-ordinator (whom I shall call Chris) and a planning and reviewing officer from the Social Services Department (Jeannette). These participants were able to inform me of their organizational structures and practices and the changes that were taking place. They were particularly useful in negotiating access to other practitioners. I conducted individual interviews with Chris and Jeannette on two occasions as part of the different stages of the data collection. However, as I was focusing on the district nursing out of hours service I visited Chris on several occasions to clarify the events that were taking place. Below I have provided a brief introduction to the key informants.

### **Key informants summary**

Chris is a 47 year old, district nurse co-ordinator of the out of hours district nursing service. She has practiced for eleven years in the community. Chris was appointed from

Craigley practice on 3rd April 2000, to oversee the development of the service, manage the out of hours team and to create awareness of the service amongst other agencies.

Jeanette is a 45 year old planning and review officer, who works for the Department of Social Services for physical disability and sensory impairment care (includes care of older people). She trained as an Occupational Therapist. Her main responsibility is for planning and development of joint services with the NHS Trust and Health Authority. At the time of the project Jeannette was working with a home care manager from Upper Valley to develop a homecare out of hours service.

## **2. The Focus Groups.**

There were two main reasons why I chose focus groups as a method of data collection. First, the interaction within focus groups is known to be particularly useful for exploring participants' own thoughts, as knowledge and ideas are exchanged and developed through interaction within the group. (Barbour and Kitzenger, 1999). Hence, through their interactions the focus groups may give some indication of the practitioners' sense of professional identity and solidarity. Second, health and social workers often hold group meetings to disseminate information or to discuss client care, and therefore it was assumed this setting would provide a '*natural –seeming*' forum to extract a range of views, which may not be accessible in a one to one interview (Morgan and Krueger, 1993, Kitzinger, 1996).

Having outlined the potential benefits of the focus groups, there were a number of challenges to be expected in moderating such groups (Myers and Macnaughten, 1999).

First, it was possible that the focus groups might diverge off on tangents and be difficult to direct to specific themes. However, I thought these digressions and elaborated stories could be a useful way of accessing the feelings and views of practitioners that may be unacceptable in 'straight talking' (Gabriel, 1998). Second, it was possible that a few participants may dominate each group (Frey and Fontana, 1994). Contrary to the thinking of some authors, I viewed this as insightful into the way the different participants positioned themselves within the group.

Third, I expected that the dynamics within the focus groups would vary and may depend on the familiarity between participants. For instance, the social care focus groups tended to comprise pre-existing teams, where staff knew each other fairly well. In contrast, the district nurse participants may have gathered from different practices to form the focus group, and therefore some members may not have met each other before.

Finally, the differing staff grades and occupational positions within a group could add breadth to the study but there was a possibility that they might hinder interactions within the group. By this I mean that some 'lower' graded staff may be guarded about what they discuss or how they react in the presence of their team leaders.

### **Sampling and organizing focus groups**

Having considered the benefits and the possible challenges of focus groups, I began to consider the likely composition of my focus groups. I was mainly interested in gathering qualified district nursing and social care staff, who had experience of joint working and

negotiating with other professionals. However, I wanted to gain a breadth and diversity of experience across the area of Spilsdale, and so, I would need to organize interviews from all levels of staff from the three localities across the valley, as well as those who were directly involved with the service developments. For example, this included the out of hours district nursing staff and the managers coordinating the developments of the two out of hours services (including Chris and Jeanette). My next consideration in the sampling process was what the most suitable size for the focus groups would be, and how I would gain access to the above staff groups.

### **Size and composition of focus groups**

The recommended size for focus groups is between three and twelve participants, outside those figures it is argued that there is either not enough 'air time' for all participants to convey their views or the group is too small for the required interaction (Bloor, 2001). I anticipated that the numbers would vary between the different organisations and within individual groups. For example, there were a smaller number of social work bases compared with district nurse practices. Numbers also varied according to staff employed in a particular base and the availability of staff at the time of the focus group (See Appendix, table of participants, p.364 -73). To ensure that there would be different levels of staff from each district nurse practice or social care base I calculated that I would need to organize a focus group for each locality (for the district nurses) and for each main base for the social care workers.

Another consideration when organising focus groups, is the on-going inter-group relationships between participants. Some of the focus groups were pre-existing groups which had a life beyond the focus group and therefore, I did not want the group participants to experience relational difficulties following the focus groups as a result of their candidness. I expected that a pre-designed interview guide would help me to facilitate the groups and perhaps draw conversations away from personal conflicts. Also, I did not want practitioners to be overly guarded because other services were present. For that reason, I decided upon homogenous focus groups consisting of either district nursing staff or social care staff. It was expected group members were likely to express their views more openly concerning how they work with other services when practitioners from other services were not in the room.

### **Negotiating access**

Initially, I was invited by the district nursing services of Spilsdale NHS Trust to assist in evaluating their out of hours district nursing service. This gave me an opportunity and legitimate permission to contact other staff groups across both health and social services. Nevertheless, access to the different services required different strategies and approaches and so I drew upon my key informants for assistance. They were essential in providing me with the telephone numbers for the main office bases within the community to contact staff, and gave me invaluable information to gain volunteers for the staff focus groups.

### **i. Accessing district nurses**

Through Chris the district nurse coordinator, I was able to attend district nurse forums and development meetings and therefore became a familiar face amongst the district nurse team leaders and to some of the out of hours team. I was introduced by Chris, as an independent researcher from the university, whose role was to evaluate the development of the out of hours service, as well as to explore the identities and roles of district nurses and social workers. In this way I was accepted as part of the group and gained the nurses' interest and confidence. Once I had familiarized myself with the area of Spildale I set about arranging focus groups. This was largely arranged through Chris. I was aware of the danger of organizing focus groups through a manager, as staff members may see the request for attendance as obligatory. However at the time, Chris had recently been appointed as the district nurse co-ordinator from Craigley practice. She was trusted and known by the district nurses as 'a good district nurse' and as 'one of them'.

Knowing the routine of the district nurses, Chris was able to give me the most suitable times and the appropriate meeting places, which would ensure a high attendance of staff to the group interviews. Also, she was able to send a circular via the internal mail to the district nurse bases, giving the information regarding the nature of the focus groups, the details of time and place. The district nurse bases were dispersed across Spildale and therefore, we arranged three dates at three different health centres across the localities of Spildale. Focus groups for the evening and 'prospective' out of hours night team were arranged at Wigglesworth Hospital Out Patients Department. Lunchtimes were the most

suitable times to arrange for day district nurses and I arranged to meet with the evening service between 5.30pm and 7.00pm, prior to their evening duty.

## **ii. Accessing social care staff**

At the time of the project, the social care staff did not have the same cross valley forums as the district nursing service, hence I was unable to access social care staff in the same way. Nevertheless, Jeanette was invaluable in providing me with names of team leaders and the best times to contact the social care bases. Unlike the nursing staff, the teams were located on just four sites. Therefore, by contacting the team managers I was able to access their staff, arrange meeting times within their office bases and conduct focus groups. Despite the lack of contact with the social care teams, the staff were helpful and friendly and were keen to participate in the focus groups. I arranged meetings at Honsley, Mistlethwaite and Wigglesworth social service bases.

The times of the focus groups tended to vary but were often prior to or following their local team meetings. I had given an open invitation to the different levels of staff at the different practice bases and I was careful to state that staff were not obliged to attend. Some staff had already had previous appointments and were unable to attend.

## **Details of participants**

The details of the staff groups are placed in the table below (fig.11) and further descriptions of the focus groups are placed in the Appendix (p.364 -73). I would point out that the majority of the participants were mature, Caucasian women and interestingly,

I encountered more men amongst the social care staff than in the district nurse teams. Overall there were 18 focus groups and four individual interviews. Many of the practitioners who took part in the first stage attended the follow-up individual and group interviews.

**Fig 11. Details of participants**

Stages	Management of Services	District Nursing staff	Social Services
<b>Phase 1:</b> Prior to launch of out of hour service May 2000	Individual interviews (2): Planning review officer (1) Coordinator of OHDNS (1)  <b>Total 2 participants</b>	Three focus groups of day staff (7,5,4), including: district nurses (8), other community nurses (5), and health care assistants (3).  One focus group of twilight and evening staff (9) -eventually OHDNS, including: district nurses (3), other community nurses (1) and healthcare assistants (5).  <b>Total: 25 participants</b>	Four focus groups (3, 12, 7 and 5 participants), including: Home care managers (3), social care assessor team leaders (3), senior practitioners (2), social care assessors (9), social care co-ordinators (8), benefits officers (2).  <b>Total: 27 participants</b>
<b>Phase 2:</b> Follow up Jan-March 2001	One focus group (2 participants). Including: Support manager and Coordinator of OHDNS  Individual interviews (2): Planning review officer (1) Coordinator of OHDNS (1)  <b>Total: 4 participants</b>	Three focus groups of day staff (3, 9, and 4 participants), Including: district nurses (6), other community nurses (7), health care assistant (1), student (RGN) nurse (1) and student district nurse (1).  Two focus groups from out of hours district nursing staff: (12 and 2 participants), including: district nurses (5), community nurses (4) and healthcare assistants (5).  <b>Total: 30 participants</b>	Four focus groups (12, 5, 4 and 5 participants), including: social care assessment team managers (4), senior practitioners (2), social care assessors (9), social care co-ordinators (5), home care managers (4) and benefits maximisation officers (2).  <b>Total: 26 participants</b>

## **Developing the interview guide for focus groups**

I adopted a similar, semi-structured interview style to the student study. Focus groups are renowned for being particularly unpredictable and therefore I attempted to prepare for every eventuality. I designed an interview guide for both the individual and group interviews (see Appendix, p.360-3). The subject areas included the following:

- Roles and responsibilities
- Understanding of changes and developments to the district nursing service
- Relationships with other practitioners
- Experiences of joint working

The schedule served solely as a topic guide and evolved throughout the two stages of conducting interviews and focus groups. Extra topics and questions were added as the groups raised various issues. The format of the focus groups varied according to the dynamics of the group and the rapport I had developed with the participants.

Generally I would commence the interviews by introducing myself and explaining the purpose of the group, followed by a broad general question or an 'ice-breaker' to encourage discussion within the group. Often the topics would arise 'naturally' from the conversation and would only require an occasional prompt when the topic had 'dried up'. Very occasionally I would interrupt the conversation for clarification when I did not understand the issues or the topic of conversation. The follow-up interviews required feedback of their opinions concerning the changes and the developments that had taken place. Hence, I included the following extra questions.

- What has happened since the launch of the out of hours service?

- Has this (development/change) impacted upon your roles and responsibilities?  
(How?)
- How has this (development/change) altered your relationships with other practitioners?

### **The focus group experience**

All of the groups were keen to participate and to help with the study. It was not difficult to gain information from all those who participated in the focus groups. Participants were willing to divulge their experiences and they responded well to someone who was eager to listen and was interested in their perspective. That is not to say there were not any awkward or silent moments. There were differences between the groups, some I built up a rapport with quicker than others and some groups interacted better than others. I shall now turn to discussing some of the group experiences, which I believe are pertinent to the study.

### **Interaction within the groups**

The way the different groups interacted with each other and with me varied across the groups and the different localities. I wondered if this reflected upon the intra-group dynamics and the size of the group. Certainly size held some importance, as within the larger groups participants tended to be more relaxed, less inhibited, and confident in discussing the issues. The smaller groups of two and three participants required more involvement from me as the facilitator and the conversation tended to be directed towards me and less spontaneous.

There were differences in how the occupational groups responded as a whole. For some district nursing groups, the group interviews appeared to be something of an occasion where teams met up with others to 'let off steam'. This was likely due to the overall dynamics of the group and the familiarity among the participants as discussed earlier. Overall, the district nurses from the out of hours district nursing service and Lower Valley groups tended to use humour to display their anxiety and annoyance with organizational policies. Occasionally within these groups, the district nurses appeared to go off on tangents as they recounted humorous stories, others would then join in with jokes to show support and often embellish the story to enhance the point they wished to make. For example the district nurses made jokes about how the NHS Trust were planning to use a particular car taxi service for the out of hours service, and made comments about how it '*kills people*'. This taxi group had recently received media attention for its involvement in a car accident, where the driver was unlicensed and uninsured. What seemed an irrelevant and exaggerated account at the time, on reflection told me something of how they supported each other and their perceptions of the Trust's treatment of their services and their needs. In contrast, the smaller district nurse focus groups from the Central and Upper Valley did not employ such humour, but displayed their disagreement through silence, 'knowing' smiles and nods.

Overall, the social care focus groups were conducted in a formal business manner. This was partly due to the timing arrangement, as often the focus groups were held following their usual team meetings. Interestingly, the participants of these focus groups did not just use covert non-verbal expressions to communicate their concerns. Compared with the

district nurse groups, the social care focus groups appeared more direct and forthright in explaining their differences (and difficulties) concerning the relationships between services, and the pressures within their own organization.

### **Occupational positions**

The different grades of practitioners within a focus group did not appear to inhibit the interactions between participants as one might have expected. On the contrary, the differing grades within the groups added to the breadth of opinions. In some cases the differences of opinion were revealing to the participants as they debated within the group. For example, some qualified district nurses were surprised that there was a difference between qualified district nurses and staff nurses in how they defined the term district nurse. On other occasions the mix of grades revealed how some positions acted out their roles in team meetings. For instance, within the social care focus groups, the home care managers and team leaders would often help facilitate the focus groups by drawing into the conversation the social care co-ordinator and other members to gain their opinions and hear about their experiences at operational level.

### **Perception of my role**

During the course of my interviews I was concerned about how staff groups may perceive my role and my position. I mentioned earlier how prior to interviewing I explained that I worked at the university and was independent of the NHS Trust. In spite of describing my role and concealing my nursing background, I felt that there was the possibility that social care workers would view me as part of the health service, and that they would be guarded

in their responses (at the time I was taking part in an evaluation project- see p.175). My concerns were confirmed in one group interview with the Lower Valley team, when a team leader referred to a group of the district nurses and health workers as on '*your side*'. In response to these comments I would emphasize that I was a postgraduate university student, and therefore providing a report independent of the NHS Trust. Contrary to my concerns, this did not appear to hinder the social care staff from expressing their views and opinions concerning their relationships with health staff. Further incidents relating to participant perceptions of my role are discussed under 'Appearance' (below).

My impressions from the district nurses concerning their perceptions of my role were varied. For the out of hours district nursing service, I felt I was viewed as a possible advocate who would put forward their concerns and complaints to the management. This was partly the case as I was compiling an evaluation report for their service. Also, there were occasions I found myself playing a counselor role, where some nurses took advantage of my position as someone who was willing to listen to their story concerning the difficulties they were experiencing. With other groups I found myself accepted as part of the whole group, as we laughed, and shared jokes and experiences.

### **Appearance**

I paid attention to my appearance when attending the focus groups and interviews, as I wanted to present myself as non-threatening and as a peer to those interviewed. I tended to dress semi- smart wearing a jacket with a blouse and formal trousers on my first visits to managers and the focus groups. This was useful as I could appear as a professional

worker and then remove my jacket to merge as part of the group. However, this did not work according to plan. The district nurses generally wore uniform and the social care workers tended to be fairly casual. I was concerned that the jacket signified management and that consequently participants may be reluctant to reveal their concerns and their everyday working experiences. On the contrary, this did not appear to inhibit the torrent of feeling and expression from the evening district nurse teams.

Another occasion with a particular social care focus group, I was conscious of being slightly over dressed and partly attributed the initial stilted and guarded discussions to my appearance. I had used the same interview schedule and topic guide on previous social care groups and so I was concerned that I may have been perceived as an NHS trust manager or an informant to management. On my second visit to this homecare service I dressed very casually with a sweater and casual trousers and shoes, only to find that the female participants of the focus group sporting jackets and neck scarves. Apart from my initial feelings of discomfort the group were responsive but remained dependent upon me stimulating the conversation with direct questions. Following the analysis it was possible that the initial guardedness of these participants was perhaps a reflection of some of the tensions that were happening (at the time) between the district nurse and social services in the area (see p.195).

Overall I have found my appearance helped to serve different purposes. I preferred casual dress as I felt it helped others to relax and just 'chat to me'. On the other hand the

semi-smart formal wear may have facilitated the district nurses in the communication of their grievances and displeasure, in the hope of these being passed to management.

## **Analysis**

Following the transcription of all of the interviews, the data were subjected to two analytical schemes. First I drew upon storytelling techniques (Plummer, 1995) to gain an overall picture of the district nursing service and the setting up of the out of hours scheme. My interest here was not in how district nurses and social care staff constructed the plot in their story telling, but in summarizing their descriptions and reactions to the local changes that they were experiencing. Secondly, I utilized the template analysis as described in the previous chapter. This gave me an in-depth analysis of the main issues that were raised by the district nurses and social care workers. I will now give a brief account of how I developed the story of the district nurse out of hours service, followed by a brief description of the development of the template analysis.

### **1. Writing the story**

The story of the out of hours district nursing service (OHDNS) did not emerge in a linear form, but resembled the piecing together of a jigsaw puzzle, as people recounted their reactions to the changes that were taking place. There were times when it was difficult to separate staff responses to the national changes from their responses to the impact of local changes. Often when discussing the local service developments, staff would refer to the changes that had taken place as a result of the Community Care Act. Nevertheless, with the help of the key informants and other supporting sources; such as, steering group

minutes, the in-house staff newspapers, and local health circulars, like the Spilsdale NHS 'Trust News' and 'Health Call', I was able to construct the story.

Because I had conducted the focus groups in two phases (the first phase was before the launch of the service and the second phase six to eight months following the launch of the service), I was able to analyse the scripts following the first stage of interviewing and then amalgamate these with findings from the second phase of focus groups. For the first stage interviews, I examined the data for core elements that helped to tell the story as a whole, rather than focusing upon the fine detail (Holloway and Wheeler, 2002). The analysis of the second stage of interviews focused upon the emerging stories associated with joint working which involved finer detailed analysis, similar to template analysis as described in the previous study. For this stage I read through all the scripts noting by hand any references to any comments relating to the plans of joint working between the social services and district nursing service. I then coded the data for staff reactions to the impending service developments and to any other issues that appeared to be pertinent to the working relationships between staff. Finally, I attempted to organise the themes in some sort of order of events. These are listed below.

The themes that emerged from the first phase of interviews and focus groups:

- Local changes
- The need for the district nurse out of hours service
- Appointment of staff
- Relocation of district nurse out of hours bases
- The development of the out of hours home care service

- Plans of joint working.

The themes and issues that arose from the second stage of focus groups were as follows:

- Joint working and relationships between the home care and district nurse service
- Differences between social services out of hours and OHDNS
- Relationships between the OHDNS and acute hospital staff
- Further local Trust changes
- Changes to OHDNS working environment

The above themes were merged to write the story of change under the headings listed below.

1. Background of local changes
2. Assessing the need for development
3. Moving bases
4. Developing and working together (homecare and district nurses)
5. Divisions (between acute and district nurse staff)
6. Working relationships between district nurses and home care
7. Summary of outcomes.

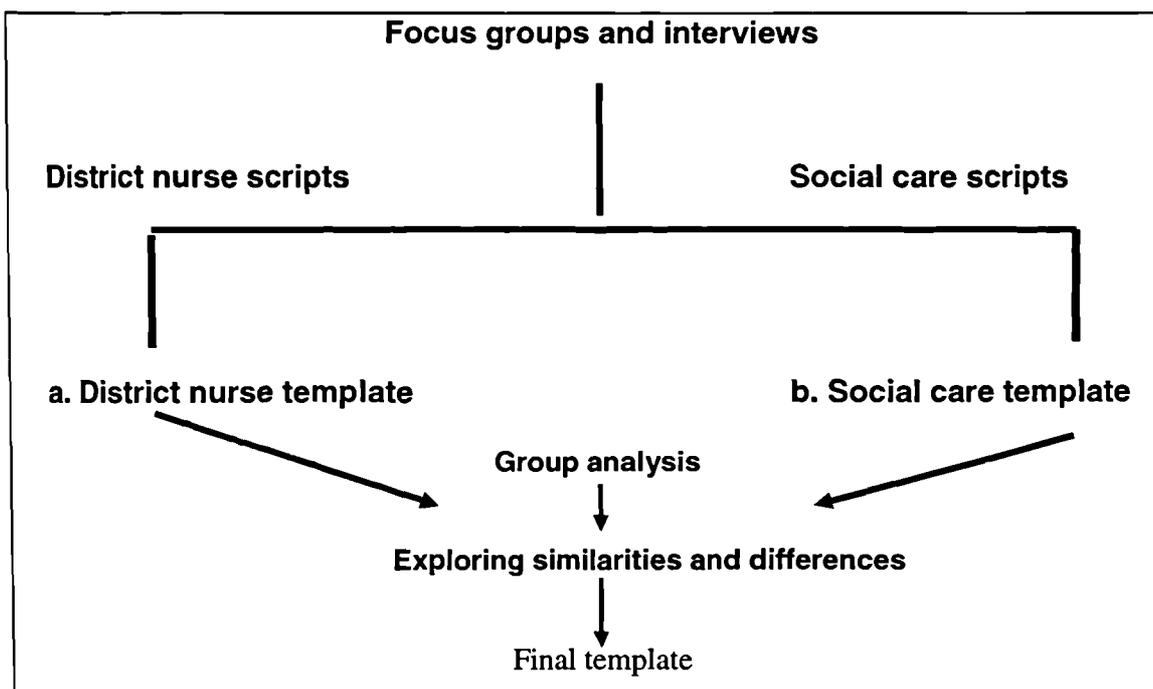
Overall there was a consistency in the details and description of both the developing services and the impending changes that were taking place. The district nurse accounts tended to agree about the main concerns and the difficulties that arose when establishing the out of hours district nursing service; for example, the district nurses' relationships with the Acute Trust Staff, and the Central OHDNS team complaints about their facilities. However, some participants were vague concerning specific dates; here the key informants were useful as they provided detailed information about the structure of their organisation, the dates of relocation to the new hospital base, the temporary arrangements,

and the provision of facilities. This information was later confirmed by minutes from district nurse steering groups and the local hospital newsletters 'Trust News' and 'Health Call.'

## 2. Template analysis

I adopted a similar strategy for organising the analysis as I did with the student study (Chapter 5, p. 99), initially separating the district nurse scripts from the social care staff scripts (see fig.12 below). Once I had identified the main themes and issues from the two groups, these were then merged to create a hierarchical order. The broad titles highlighted the general issues that were identified throughout the scripts, and the lower order codes provided the depth and specificity.

Fig. 12 Analytical strategy

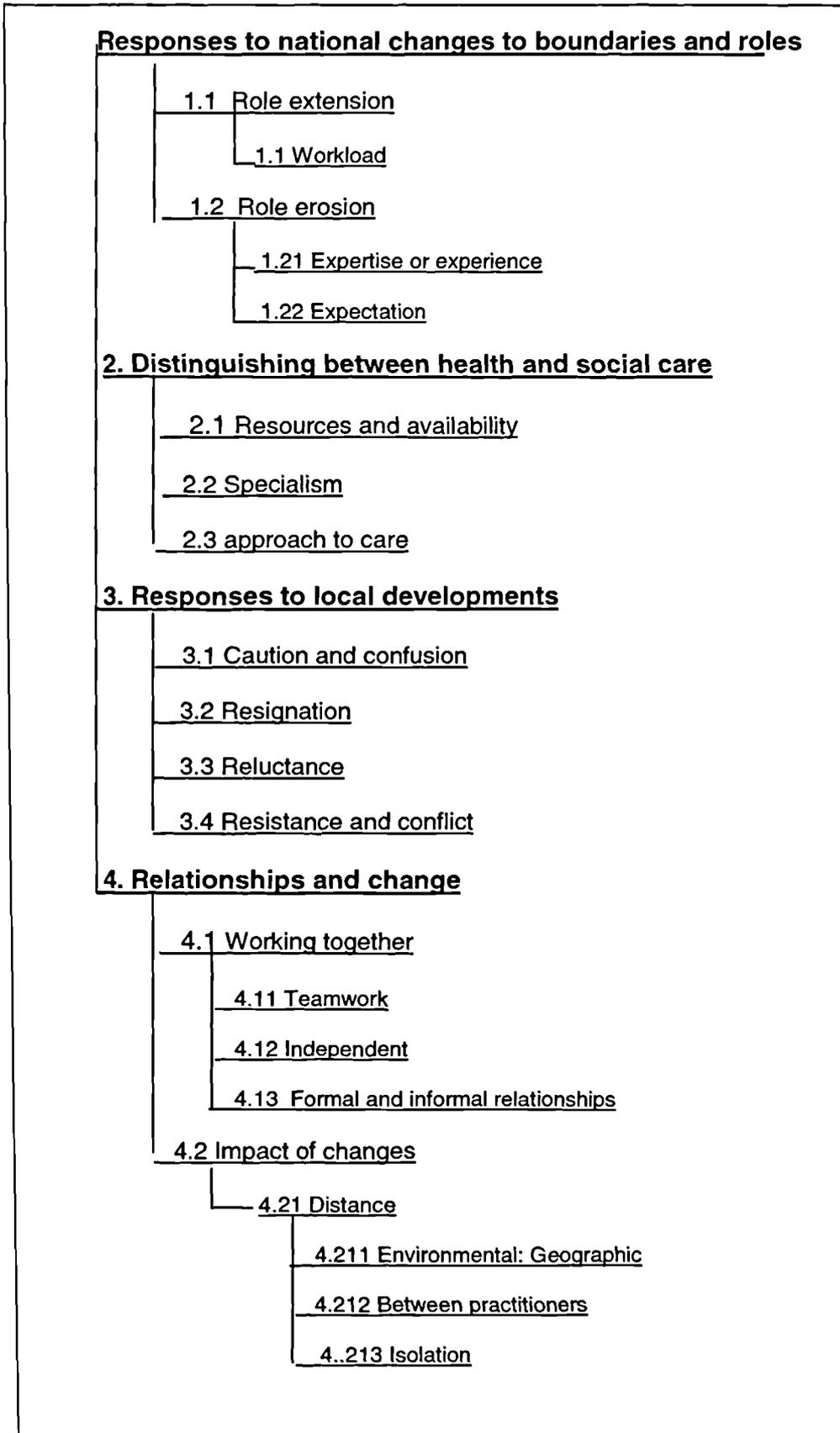


## Organising the data

The notes I had made from the story writing had formed a good foundation for the second stage of analysis. I had summarised the notes highlighting the significant or interesting points raised by the different participant groups, and examined these along with my field notes. Following the completion of the second phase of focus groups, all transcripts were transferred onto NVIVO2 for ease of coding, storage and retrieval of data. I then formed a list of initial codes (nodes) from one transcript by turning the notes I had made into titled themes. I proceeded to use this initial list as a guide for subsequent transcripts. In this way I was able to identify differences between the groups as I worked through the data. For example, the sense of *isolation* was a recurring theme with the district nurses but was not apparent in the social care staff data. The themes that emerged from both the social care staff groups and the district nursing groups are illustrated in tables in the Appendix (p.374).

The template developed into a list format, similar to a catalogue, which illustrated the range of views and responses. Therefore I reshaped the template to capture those themes that appeared most important to the practitioners, in terms of how they construed their professional identity and their roles in a changing environment. The following is a revised master template.

Fig 13. Final template of focus groups



## **Chapter 8.**

### **The development of an out of hours district nursing service:**

#### **Part two: Findings and discussion:**

In this chapter I have presented the findings into two sections. The first section, 'A story of change' provides a historical, narrative account of the development of the district nursing service. The findings include the viewpoints of both social care workers and district nursing staff. The second section, 'Template analysis of staff responses', provides the findings of the detailed template analysis described in the previous chapter.

### **1. A story of change**

#### **Background**

In response to the political drive towards providing efficient and patient centred services (DOH 2001<sup>2</sup>), health and social services underwent organisational changes both at a national and local level. Spilsdale was no exception. Over the two years I studied and visited the area, the primary care services had experienced two major structural changes at management level. First, the administration of these services was managed and funded by the Spilsdale Acute Trust. Then, following a merger with an adjacent NHS Trust, the Acute Trust became Spilsdale and Fernley NHS Trust. Secondly, plans were being made for the primary care groups to become self-managing as the Spilsdale Primary Care Trust by 2002.

---

<sup>2</sup>DOH 2001 Shifting the Balance of Power within the NHS. London HMSO

Apart from the administrative changes, both health and social care staff had to adjust to numerous organizational developments, and to the centralization of services that were taking place at operational level within the area. One important change was the closure of three community hospitals and the relocation of hospital and (some) community services to a new hospital in Wigglesworth. This rebuilding programme evoked a sceptical response from both nursing and social service groups across the NHS Trust. They anticipated that the new hospital facilities would accommodate fewer in-patients, and therefore may increase service demand within the community.

Ex 2.1

*Georgina: I think when the new hospital gets done and they have less beds than they started with - I shouldn't say, but because the people who'd normally have been staying overnight even for an anaesthetic, we (the Trust) might be sending them home a lot earlier. I know people who for example we send home, years ago we would have kept them in. They come home with drips and all sorts now – we (district nurses) will all be doing open heart surgery [laughs].*

(District nurse - Upper Valley)

The possible increase in patient demand in the community meant the community services had to address both how they could provide additional care, and how they need to adjust their roles and relationships with other services. To demonstrate the dramatic impact of such organisational changes and developments upon roles and relationships, I shall focus upon one service development and that is the extension of the district nursing service.

### **Assessing 'the need' for development**

Prior to the development of the out of hours service, the district nursing service provided day nursing support, generally from 8am to 5pm and an evening service, from 7pm to 11pm. Outside those times, daytime district nurses would give their mobile phone numbers (for emergencies) to known long term or palliative care patients. However, it became apparent to both hospital and community staff that there were a number of other unnecessary medical and nursing admissions to hospital, as a result of the restricted times the district nursing staff were available. In support of staff assumptions, an annual hospital audit identified that certain patients were being admitted to hospital in the night, who were otherwise successfully maintained in the community during the daytime; for example, patients with long term chronic conditions and those with catheters. In response to the findings of the hospital audit Spiltsdale NHS Trust (as it was then) was able to release specific funds to initiate the development of the out of hours service. On April 3<sup>rd</sup> 2000 a district nurse co-ordinator, namely Chris was appointed to oversee the service developments and manage the out of hours team.

The 'new' out of hours district nursing service would comprise of the existing evening team, from 19.00 hours to 23.00 hours and an additional overnight team to cover from 23.00 hours through to 08.30 hours. The evening district nursing staff consisted of the following three teams across Spiltsdale: the Central team based, at Dyer Place Health Centre Wigglesworth , the Upper Valley team based at Honsley clinic, Rossington; and the Lower Valley team based at Elgin Road, Mistlethwaite. The 'new' overnight service team would include the co-ordinator (Chris: H grade), three qualified district nurses (G

Grades) three staff nurses (E grade) and seven healthcare assistants, all working part-time. This overnight team would be based on the same site as the Central team. It was expected by management that the launch of the extended service would be in June 2000

### **Moving bases**

The relocation of hospital services meant that the Central evening team and the impending overnight district nurse team, were to be transferred from Dyer Place to the Outpatients Department (OPD) at Wigglesworth General Hospital. This was only to be a temporary arrangement as their final destination was promised to be on a dedicated site at the new Royal United Spilsdale with the other out of hour services.

On the surface the temporary location of the Central team and the night team at the OPD base appeared to be a good move, as this meant the out of hours district nursing teams would be ideally placed for working with other community night services. For example the GP deputising co-operative for out of hours calls was placed on the same site at the 'General', and it was expected that the future overnight homecare service would be working from the same base. Community nursing managers encouraged their evening district nurses by saying that 'things would get better', and this move would particularly provide the opportunity for closer working relationships between home care and the district nursing service.

I interviewed the out of hour district nursing teams on their first visit to the temporary base. Many of the evening staff from across the three localities attended the focus group,

curious to visit the Central base and keen to contribute to the discussions. To accommodate the number of staff arriving for the focus group I had to utilise a waiting room within the OPD. As they looked around it was obvious by their reactions and humour that the district nurses were disappointed, if not disgusted, with the temporary arrangements. The office they were to use was quite small, and was being used in the day as an outpatient room for coronary investigations. At the time there was only one telephone (they informed me they were promised two phones for their needs) a small desk and an examination couch, hence there was little space for their paperwork and equipment. Therefore, when it came to talking about their reactions to the changes that were taking place, the district nurses were uninhibited in expressing their feelings as well as their anxieties concerning events. In many ways they were venting their anguish and frustrations in the hope that I might communicate these feelings to the management.

Ex. 2.2

*Shona: We went to all the initial meetings of the setting up of the service, what they were going to do and what they weren't going to do, but I knew it wouldn't going t'happen. We were told all along we will have all the equipment, don't worry, it will be all provided. We were suppose to move on the 15<sup>th</sup> (weeks ago) but there isn't anything in place and it's not in place now. We got to move in.*

(District nurse :OHDNS, Central base)

Ex.2.3

*Shirley: It's disgusting! There's no service the Trust has set up which would put up with such a lousy working environment as we have had to put up with*

*in this service, it's rubbish! It's appalling it really is!*

(District nurses: OHDNS, Central base)

It emerged from the focus groups with the out of hours staff, that the district nurses were expected to share their facilities with the daytime outpatient department staff. There were concerns about how they were expected to manage the hand-over period each morning when both staff groups would need to use the tiny office. For example, they were unsure how the night team was going to manage contacting daytime district nurse bases, completing their paper work, while the OPD staff were trying to prepare for the start of their clinics. Also, by sharing office space there would be the difficulty of ensuring the confidentiality of district nurse notes in a room that is largely used by the general public. They raised questions such as where were they going to put their staff rotas, their memo boards and their case notes?

Concerning the lack of storage space, they were told by their co-ordinator (Chris) that Trust managers had allocated cupboards in another part of the hospital. This was felt by the Central evening team to be inadequate, as they anticipated access to their equipment would be difficult and time consuming. Added to these concerns were the issues around parking and security. From their first impressions, access to their office base was through an outside door opposite the A and E department, and therefore they had little space for parking. Furthermore they were unsure of their safety during the early hours of the morning, because after midnight the on-call GPs would return to their main base, on the

other side of town. The overnight office was isolated from the main section of the hospital, they felt vulnerable to possible intruders or 'drunks' from A and E.

### **Developing and working together**

Simultaneous to the development of the OHDNS, the Home care Service was developing an out of hours service to be launched in the summer of 2000. This service was to be based at the same hospital sites as the extended district nursing service. Initially, the night team consisted of two home care assistants and was co-ordinated by a day home care manager. The two home care assistants would provide planned personal care to clients requiring assistance over night; for example, those requiring assistance going to bed or turning in the night had to be referred to the service the previous day.

Managers co-ordinating the out of hours home care and the district services, had both expressed how they had a good working relationship. The managers had met regularly and were enthusiastic about the prospect of working closer together as a unified team. Below, Jeanette describes their plans and hopes to me concerning the future development of both services.

#### **Ex.2.4**

*Jeanette: We are not trying to develop our services in isolation of each other. We are very genuine about wanting to develop jointly. So for example, on the out of hours home care service our aim is that we will start the service, probably be a little bit behind the District Nursing Service, but we are going to share premises, we are going to work together. It may be in the long term*

*they (the two services) will become almost a joint managed service. By sharing premises, by sharing information, by sharing facilities we will hopefully prevent a lot of duplication of provision and as I say I would see that ultimately it (will be) managed as a joint service.*

(Development officer, Social Services)

The district nurses (OHDNS) were encouraged by their managers to work with the homecare teams, and they supported their managers' vision in the prospect of teamwork between the two services. However, from my talks with the evening district nurses it transpired that many of the evening district nurses had no contact with social services or any experience of working with them, because social services did not provide a 24 hour, seven day a week service. Consequently, the district nurses did not know how the proposed changes were going to work, or what to expect.

### **Divisions**

Eight months later I made my second visit to the OHDNS at the OPD. The extended service had been operating from the ECG clinic OPD for approximately six months. The central team and the overnight team were expecting to be moved again to the new hospital site as soon as the building was completed.

Since the move to the Out patients department, I had found that the sharing of facilities had not promoted good relationships between hospital staff and district nursing groups. Many of the (OHDNS) night team reported unhelpful attitudes by OPD staff, and were made to feel very uncomfortable and unwelcome within the department. In particular, the

night team felt the hospital staff did not understand them, and that little respect was given to their role and their equipment.

Ex.2.5

*Shona: We are talking about your base and how you work effectively, the staff (OHDNS) coming in on a morning you get funny looks (from OPD staff), "this is our space and you've got half an hour within which to sort this out!"*

(District nurse, OHDNS, night team)

Chris explained further,

Ex.2.6

*Chris : I think the problem is that people who work in the hospital see it as their territory, they have a right to be there, and they don't see us (district nurses) as having an equal right to be there.*

(District nurse co-ordinator, OHDNS)

There was further conflict between acute and district nursing staff, with regard to the storage of their equipment. At first it was agreed by management that they could utilise cupboards on an empty acute medical ward, above where they were based. This inconvenience was tolerated by the district nurses and worked relatively well until the ward was needed for a high dependency unit, whereupon their equipment was ejected by the ward staff into the corridor without consultation with the district nurses. This action appeared to strengthen the district nurses mistrust towards the Acute Trust management and created further animosity towards acute nursing staff.

The move to the new hospital site would have appeared to have been the solution to the untenable working environment the Central evening and night team had to face. Unfortunately, their hopes were to be deferred yet again. The teams discovered that a dedicated district nursing area was not even included in the plans of the new hospital, and so this meant sharing again and being subject to resentful day time hospital staff. The anguish and hostility towards the Acute Trust is expressed in the comment below.

Ex.2.7

*Shona: I'm aware of, we're going to fracture clinic so we're sharing. All that we've been told 'we have a room here, don't worry it's going to get better' I can't believe it! I have nothing to say to them folk (Acute Trust management) out there.*

(District nurse: OHDNS,night team)

Ex.2.8

*Shirley: If Trust managers cannot be seen to take us seriously and treat us with a bit of respect and give us reasonable working environment, how can the public be expected to do it? They (Trust management) have just let us down!*

(District nurse, OHDNS, night team)

From my first interviews it was felt that the extension of the service was set up in a hurry without considering district nurse needs. The district nurses (OHDNS) eventually came to the conclusion that their needs had just not been considered from the beginning.

Ex.2.9

*Shona: We (district nurses) don't fit in anywhere we never have done. They (Trust managers) put us in here (OPD)' cos there was nowhere to put us. They had plenty of time (to sort something out). They couldn't even find a cupboard for three months!*

(District nurse OHDNS, night team).

Ex.2.10

*Shirley: They told me it was a secure place here – we never see a porter nobody comes here all night – I just feel..*

*Amelia: They put value on the service – but undervalue the service.*

*Shirley: What other service would you start anywhere without having an office or something its just gone back to where they push nurses in smallest office they can find.*

(OHDNS, Evening team)

Later, I was unofficially informed by community management that the delays in providing dedicated facilities to the district nurses (OHDNS) were probably due to the way the community health services were funded through the Acute NHS Trust. It was hoped their situation would improve once the Primary Care Trust was established. Also, with the rising costs of the hospital rebuilding programme, it was suspected that funds were reaching crisis point, with little to spare for their needs.

### **Working relationships with home care out of hours service**

During my preliminary interviews with the out of hours services, there were high hopes of joint working between the homecare and district nurse staff groups. In spite of the regular contacts and discussions between the managers, joint working did not develop as they had anticipated. The district nurses (OHDNS) were very disappointed and these (joint working) difficulties added to the disillusionment they had begun to feel concerning the development of their service.

From my talks with both service groups, there were a number of factors, which appeared to hinder their joint working effort. First, the home care out of hours service was not located within the OPD as expected, but was finally placed in the social services department called 'the lodge', at the entrance to the hospital. This arrangement enabled the home care night staff to access their Social Service referrals and notes on the computer filing system, which were not accessible on the hospital computer system. Consequently, there was little contact between home care and district nursing staff. Also, Debbie, the homecare manager, pointed out that the home care team were out in the community most of the night on planned visits.

This brings me to the second point; the differences in the way the two services operate and finance their services. The home care management had ascertained, before the developments described above, that their service was to be a planned service. This meant requests for visits by their team would have to be made by 12 am the previous day, and be processed through Social Services according to their allocated budget. In contrast, the

district nurses could attend to both planned and emergency (or unplanned) referrals, where necessary without seeking approval from higher management. Because of these diverging approaches, it was difficult for the service managers to initiate collaborative working. Finally, there were differences between the respective organisations in terms of staff pay and working conditions. This created tensions and obstacles on both sides, which as Chris (OHDNS) commented ‘*scuppered totally the working together*’. For example, it transpired that the health care assistants would be receiving less pay from the NHS Trust than the home care assistants working for the Social Service Department.

The district nurses were somewhat more disappointed with the lack of joint working than the home care services: this may be as a result of the above organisational obstacles, and the conflicts they were consequently experiencing with hospital staff. I would also suggest that with the expectation of acute nursing needs appearing within the community, perhaps it was hoped that home care would relieve the district nurses’ work load pressure by attending to some of the needs of long-term patients. However, the home care team appeared satisfied that their services were working in a complementary way to each other, even if they were not literally working together. The home care team perceived that they were providing a separate service, meeting different needs and providing additional care. As Debbie (home care manager; Honsley) commented, ‘*they have their role and we have our role*’.

### **Utilisation of the service**

I will briefly outline the utilisation of the out of hours district nursing service. At first the community managers and the district nurses were apprehensive about publicly advertising their services until they were fully staffed. Their cautiousness was because they expected 'the flood gates to open' as a result of the reduced number of hospital beds, and because of the possibility of inappropriate referrals from hospital staff and patients. Also, they anticipated there would be left-over day work from the district nurses, as the (day) district nurses' workload increased. On the contrary, once the service was launched the night team (OHDNS) reported a relatively low use of their services than expected and many of their initial concerns over referrals were unfounded.

Over the following six months there were a gradual increase in the number of calls and visits. The majority of the calls were for catheter problems and this did not come as a surprise for the OHDNS night team. They would joke about this in the focus groups by referring to themselves as the 'catheter queens'. In addition to these calls, a number of their visits were for palliative care, technical tasks, such as dealing with syringe drivers, wound care and injections. As the service developed they began to extend their services to provide out of hour links for other community projects. These included out of hours contact and advice service for clients from the Diabetic Centre, the 'Rehab at Home Team' and 'Careline'<sup>3</sup>.

---

<sup>3</sup> An accident and response team for the elderly

## Summary

The development of the out of hours service highlighted the tenuous relationships that existed between hospital and district nursing staff services, and the difficulties of forming collaborative relationships between hospitals and home care services. From the data so far it appears that the relocation of services and the number of changes experienced by both hospital and community staff did not facilitate collaborative or co-operative relationships. Furthermore, the events surrounding these changes appeared to reinforce the notion that Acute Trust management and staff did not value district nursing skills, nor understand district nurses' contributions to care. The district nurses argued that, in spite of discussions between themselves and Trust management, their needs were not acknowledged and the hospital management had failed to provide them with the facilities to perform their role.

Ex.2.11

*Shona: We've (district nurses) always been pushed into like little cupboard in the past. We're like the forgotten service aren't we. We've always felt that, but we thought when this new service starts, we thought oh you know we're being pushed to the front of it, this is new a service and (the management say) 'we are going to provide all the room for the service'.*

(District nurse: OHDNS Central Wigglesworth)

The overall feeling among the evening district night team was that district nursing was still viewed by hospital staff and management as a Cinderella service - a forgotten service, and one, which was not a financial priority.

The story so far suggests that the changing work-place and location of the district nurses appeared to have an important impact upon how they viewed their role, their identity and their relationships with other practitioners. Initially many were keen about the changes, but were soon disappointed by the lack of joint working, the misunderstandings by other staff, and the lack of support by the Trust management. The day district nurses and the other evening teams were not expected to move bases, and some district nurses were not directly involved with the development of the out of hours service. Therefore it is essential to ask, to what extent are these perceptions of identity and reactions to change unique to the night and evening Central teams? How have the organizational changes and developments impacted upon the roles and relationships of other district nursing and social care staff? I will now explore these questions by examining the data gained from the day district nursing and social service teams.

## **2. Template analysis of staff responses**

The master template outlined in the previous chapter provided an exhaustive source of information for the evaluative report as well as for this thesis. Many of the emerging themes supported the findings in the student study. For example, Therefore for the purposes of this part of the study I will solely focus upon the following template themes; staff responses to the national changes to health and social care boundaries, staff reactions to local service developments and the relationships between district nurse and social care services.

### **National changes to health and social care boundaries**

Throughout my discussions concerning the local service changes, both social care and district nurse groups consistently referred to the broader national legislative policies that had taken place as a result of the Community Care Act of 1990. For all of the staff interviewed, this had the greatest impact upon how they viewed their roles and relationships with other services. Amongst the changes discussed the most pertinent issue was how certain aspects of nursing care had devolved to social services. For example, prior to the Community Care Act the home care services had provided domestic and social care; now this had gradually changed to social services providing personal care that was traditionally a part of the nurses role, freeing district nurses to perform more specialised tasks. It became apparent that such dramatic changes to roles had raised underlying issues associated with the occupational identity of district nurses and social care workers. These are most evident when examining the group responses to their changing roles.

On close analysis of the scripts I identified contrasting responses to the changes that had taken place. On the one hand there were those who felt their roles had extended and were happy to move towards something that they perceived as challenging and more interesting than before. On the other hand, there were those who were perturbed by the changes and felt their roles and boundaries had been eroded.

### **Role extension and erosion**

#### *i. Responses from social care staff*

Overall, the social care groups expressed that their staff were keen to take on aspects of the nurses' role.

Ex.2.12

*Debbie: Most of them are fine - they find it more interesting than just doing cleaning, shopping and ironing.*

(Home care manager; Upper valley team)

Ex.2.13

*Janet: I think it's better for the staff that are out there doing their job, it gives them more interest, more variety.*

(Social care assessor; South Wigglesworth team)

Staff found the extension or the changing of their roles made their work more interesting and varied. However, staff groups expressed various concerns about the changing roles. There were those who were willing to adjust to their roles and take on other tasks, but were constrained by how the public perceived the roles of a nurse and the home care service.

Ex.2.14

Rob: *We had a case this week where the attitude of the service user has been 'but you're not a professional, we want a nurse because a nurse is a professional! What are your qualifications?' It's all right saying, well maybe 95 to 99% of the population will accept us taking blood pressures and all the rest of it, but there's always somebody going to turn around and say 'well what is your qualification for doing all of this?' You say 'well I went on a half day course a month or two or back', it's probably not going to sound quite so professional as somebody who says 'I've got SRN'.*

(Social care assessor and team leader of Upper valley team)

The above comment highlights how some social care staff are not necessarily concerned here with the ability of the homecare staff to perform nursing care roles, but are concerned about being accepted by the public and patients when performing these roles.

However, there were social care staff who were concerned with the ability of home care assistants and the expectations placed upon them. It was felt there were instances where the changing of roles had placed expectations upon home care assistants to provide nursing care, which some staff felt they were not trained for.

Ex.2.15

Janet: *We've (social care) got a different understanding a different knowledge and we sometimes get quite concerned with the expectations that are put on home care assistant in a situation. We are concerned about the safety aspects because it might be seen (by management) as just being a basic care task, but there could be*

*associated problems that if you don't have a nursing background to know what to look for there could be complications. Yet it seems quite unfair if we are expecting an unqualified person to be going in on that role.*

(Social care assessor; South Wigglesworth social care team)

Overall, the social care groups felt the extension and flexibility of roles was a good thing as it provided a generic service responding to a variety of needs, but they were concerned that they would become a dumping ground for the tasks that other health and other social services did not want to do.

Ex.2.16

*Joan: Learning disabilities (Social Service dept) have said 'no (to referrals), not ours' and they (learning disability clients) have ended up with us because there is nowhere else for them to go and they (learning disability clients) can have quite a high input.*

*Tony: I think they (learning disabilities teams) define themselves as specialist teams and we're the dumping ground, because we are not a specialist team*

(Social care team; Central Wigglesworth)

It transpired that they felt that other services were passing them on work because social care was not recognized as a specialist service and therefore, their skills were undervalued and unrecognized by other practitioners. This view was supported by other social care groups and is illustrated in the example below.

Ex.2.17

*Christine: I think people think what we do is 'oh anybody can do it'. It's not specialised, like nursing is a very specialist job. That nurses could do our job,*

*they can, I'm not saying they can't, what I'm saying is there is a skill in what we do and I think sometimes that's underestimated.*

(Social care assessor; South Wigglesworth)

Along with feeling left with the odd jobs, there were also concerns shared by some team leaders who felt that perhaps multidisciplinary working with health services could mean further financial 'cut backs', and less input into their professional development.

Ex.2.18

*Jane: I've always enjoyed working in multidisciplinary settings. Personally, professional point of view it is a worrying time. We feel we are being subsumed, I feel you are (referring to health services) much better at getting research projects like you've got millions out there who seem to be researching and development working and project leading and loads of money. We are really paired down. It's a big gap! We (social care staff) are out numbered (by district nurses) and we do not put the money in. We haven't got the money. You've had all the money (referring to health service). We've been cut for years! We provide good services and we are really (financially) tight.*

Social care assessor and team leader: Mistlethwaite, Lower valley)

## ***ii. Responses from district nurses***

In spite of the keenness of home care staff to take on nurse roles, there was a mixed response from the district nurse focus groups in how they felt about transferring such care. There were some district nurses who were happy to leave the traditional aspects of nursing care behind.

Ex.2.19

*Claire: I think it's quite exciting and stimulating that's what I want to be involved with rather than washing people and getting them up.*

(District nurse Coordinator; Central Wigglesworth)

Ex.2.20

*Maryann: We do things now that we wouldn't have done 20 years ago it's a progression – things are still changing- it's exciting really.*

(District Nurse)

In contrast, other district nurses viewed personal care as an essential component to their role. This is expressed in the comment below.

Ex.2.21

*Kath: Don't get on me about social services I just feel totally out of my role! They have skimmed off the top, I feel left with the odd jobs.*

(District nurse; Holroyde, Lower Valley)

The strong reaction behind Kath's (and other district nurses') responses urged me to explore this in more detail. Why did she feel out of her role, and not inspired, as others were by the move towards more technical nursing tasks? On further examination of Kath's comments it seemed as if she no longer identified her work with nursing. Furthermore there was a sense of loss where she felt her role had been eroded - '*left with the odd jobs*' -leaving her no longer in control over some aspects of her work. Hence, it may be deduced that role erosion here is associated with a loss of ownership and a lack of autonomy over the way district nurses now work. This is further demonstrated by Tanya's remark below.

Ex.2.22

*Tanya: well we found down at Honiston House end, the social services seem to be taking the lot from us . We've seem to have lost our completely old patients. I'm beginning to feel that we are getting squeezed out!*

(District nurse; OHDNS, evening staff)

Here Tanya suggests that there are certain clients and territory that should belong to the nurses, and that these are being taken from them. Likewise, comments from other district nurses seem to suggest that they feel home care assistants are taking on 'too much'.

Ex.2.23

*Georgina: My personal opinion of social services is that they (social services) just have anybody. They (home care assistants) are not trained people going in. We have to show them how to do a bed bath. It's just somebody off the street and they (home care assistants) go in.*

*Janice: They have a nice uniform.*

*Georgina: They have a nice uniform this young girl. Well she was a mature woman actually and probably would have cared for her children and its all common sense at the end of the day. But to actually roll a person it isn't!*

*Janice: I think they take on a lot more than they should. They don't just take on personal care, but taking on the ear drops, the eye drops medication.-*

*Martina: Catheter care*

*Lisa: Yes, and dressings.*

*Georgina: They haven't been shown how to. I don't think there has been any*

*professional input to show them how to do it!*

(District and community staff nurses; Wigglesworth, Focus group 1)

From the above example, there is indignation that untrained workers are permitted to take over such care without supervision or some 'professional input'. The home care assistant is viewed as a poor substitute for a nurse and cannot provide nursing care equipped with 'common sense' and a uniform. The district nurses here appear to claim that certain aspects of care can only be performed by nurses because only they have acquired the necessary expertise and training.

This reaction to the devolvement of nursing care may be attributed to concern for the client, who is at the mercy of untrained workers. I would also suggest, that the district nurses' reaction indicates that they feel their nursing care role is undervalued and unrecognized by others. This view is further supported by the comment below. Chris described how she felt her district nursing care role had been eroded.

Ex.2.24

*Chris: When I did my training the emphasis was very much the district nurse being trained as an assessor, holistic needs and stuff, but it almost seems now that this has been devalued and doesn't matter. 'Well (the view being) you don't need district nursing qualification to care'.*

(District nurse co-ordinator; OHDNS)

For many of the nurses personal care is an essential part of their professional role, they view it as an acquired skill and more importantly, it is something that distinguishes their profession from others. Also, they may fear transferring personal care to social care

assistants might alter the focus and values of nursing from a holistic to a task orientated approach.

### **Reactions to local service changes: development of OHDNS**

In many ways the development of the OHDNS appeared to be overshadowed by the local organisational changes that were taking place (described in the first part of the findings), and for many of the staff groups their responses were reactions to all of the local and national changes that were taking place. However, from the analysis I identified a number of reactions that appeared to be specific to the local changes they were experiencing, which I have outlined separately below.

#### ***i. Caution and confusion***

Many of the different staff groups were cautious in their responses to the development of the OHDNS as they were unsure how this it going to affect their roles or impact upon their service.

Ex.2.25

*Jo: It's like going into the unknown really*

*Beattie: It's like any other service that is provided it will get used it can be busy, yes it does keep people at home and avoid admission to hospital that can be a good thing too, but that will impact on us both day and night (in terms of workload).*

(Team leader and social care assessor; Central Wigglesworth team)

Other staff groups were positive towards the impending new service and other organisational changes, but were unsure how things were going to work at operational level. However, the number of other changes, and the differing services that were emerging confused staff groups. They were particularly unsure about the responsibilities of care and found it difficult to remember all of the information they were receiving.

Ex. 2.26

*Jane: It's very confusing. I know there are lots of things coming up, new initiatives and I think, we talked about some at our meeting on Tuesday and everybody's left with their head spinning and thinking 'well where does that fit into that?' enablement services with the rehab team and crisis, no urgent rapid response team, step up beds, step down beds, out of hours, and hospital at home, hospital outreach team, and you're left thinking 'wait a minute, who does what?' So at the moment I think there's a lot of good things going on, a lot of new initiatives and I think it's great, but I think we need, here we need to be sure of who's doing what and how we access it and who provides what.*

(Social care team leader; Lower Valley team)

## **ii. Resignation**

Change for many was viewed as a frequent, inevitable event that they had little control over.

Ex.2.27

*Lauren: We have all got used to facing new challenges and what's thrown at us*

(Social care assessor; Central Wigglesworth team)

At first, a similar response came from the OHDNS focus group.

Ex.2.28

Shona: *We just have to take it on the chin as it comes, because we don't actually know, it's an unknown quantity isn't it.*

(District nurse; OHDNS, night team)

For some staff groups change was something that they just had to get on with.

The evening district nursing staff were expecting a series of changes as a result of the development of the OHDNS. This meant for the Central team different ways of working and a different place of work. Initially the Central (OHDNS) team stated that they were excited by the impending changes. However their reactions changed when they realised they would not be able to work with the same type of facilities as they did before. Therefore they were not happy to just accept what they felt were dramatic changes as a matter of course, and were prepared to seek trade union advice in how they could oppose the move.

At first it appeared that the way day staff responded largely depended upon who stood to gain or lose from the changes that were taking place. Therefore, I expected that the day district nurses and social care staff would be more compliant towards the changes as fewer adjustments to their working practices would be required of them. On the contrary, the community managers described the responses of some of the day district nursing staff as 'wary' and putting up 'resistance'.

Ex.2.29

*Chris: The day teams are certainly very reluctant to take on any new developments and they're reluctantly doing the intravenous training, they haven't all gone and done the course, which they need to do. Obviously because of the pressures on them in the daytime.*

(District nurse coordinator: OHDNS)

The above seems to suggest that the nurses were not reluctant to develop their skills because they did not like change but were more concerned about the pressures of workload and being able to support the demands that were made upon them.

## **Relationships between services**

### *i. Distance*

When it came to negotiating care between the services, the majority of focus groups described their relationships between the district nursing and social services as good or improving. However this did vary geographically. For example, both social workers and district nurses from the Lower Valley teams reported good relationships and good joint working experiences. The communities surrounding Mistlethwaite were smaller than Wigglesworth and the social service and district nurse bases were in close proximity. Many of the staff had worked for years in the area and had got to know each other through regular meetings and working together.

A few individuals commented on how they thought this had changed since the restructuring of the Social Service and relocation of social service bases. Chris (OHDNS:

co-ordinator) had been working as a district nurse in the Lower Valley before the Community Care Act was enforced in her area, she describes the changes below.

Ex.2.30

*Chris: We had really good working relationships but that came to an end with the Community Care Act legislation, because of the social workers purchaser -provider split. The social workers became the assessors and they still contacted us but not in the same way. I think we (district nurses) seem to be very much more of a margin if they remember to get in touch they did but it wasn't an automatic thing.*

(District nurse coordinator; OHDNS)

Jeanette also recalls how organizational changes had affected relationships.

Ex.2.31

*Jeannette: We did use to have locality meetings in each of the four localities, which involved district nursing staff, social work staff and myself and my other colleagues in planning. We were the people who organized those, it was to try and bring people together in the localities and all this about communications and improving relationships, they have fallen by the wayside primarily because of restructuring of both our organizations.*

(Planning and development officer; Social Services)

The enforcement of legislation had hindered relationships between district nurse and social care teams rather than improved them. Significantly, structural changes to the

organizations had transformed relationships from informal friendly meetings between district nurses and social workers to formal meetings that needed to be arranged. These were not so regular and could easily be forgotten or disregarded. Consequently, it could be said that as the district nurse and social care services developed, so the relationships between staff changed and became more distant.

Ex.2.32

*Jane: We used to meet with the nurses once a month collectively now we are a much bigger team. We split it so two members of the team meet with each district nurse team monthly, to just have a general liase talk and act as a communication conduit. It's a shame not everybody meets all the nurses like they use to. The nurses couldn't turn up that regularly and it (the service) got too big. I think this is working quite well - we have a regular feedback at our meeting. I miss out a bit, I don't know what's going on now, but it s just got too big.*

(Team leader and social care assessor, Lower Valley]

Gradually, as both the service and the number of staff increased, it became difficult to maintain the close relationships that had been formed.

In contrast with the Lower Valley district nurse teams, the Central and Upper Valley teams did not appear to have established relationships with social care services. Consequently, district nurses described their relationships with social services as more distant than those experienced by the Lower Valley teams. Interestingly, some social care staff found that health staff were not friendly or helpful when it came to joint working.

*ii. Isolation: the need for formal relationships*

It was felt by some staff groups that the local reorganization of services had made them feel isolated from their own service, as well with other services. This was more notable with the district nursing groups than with the social care teams.

Ex.2.33

*Anna: We (district nurses) don't have meetings like we used to do and at weekends people used to meet up, but because people don't call now they're not coming in to the areas so you don't meet with your peer group like we used to. It's become very isolated hasn't it? Very isolated.*

*Linda: What you see is our little clutch.*

*Anna: Yes and that's it a lot of the time. I just think it's good to meet up with other colleagues and share experiences or whatever. I know we have clinical supervision now but it's still not quite the same as. I mean I would guess I don't know half the district nurses that work here now.*

(District nurses; Central Wigglesworth )

Ann and Linda were based at a small health center and since the organisational changes, they did not have a lot of contact with other district nurses. Therefore, meeting other district nurses would be regarded as particularly important to them. Notably when district nurses met together there seemed to be a sense of belonging, camaraderie and support, as I experienced when I interviewed the OHDNS team. In some ways informal meetings held a special quality that was able to fulfill their needs better than formal district nurse forums created by the community managers.

The social care groups did not seem to feel isolated from each other but made similar comments to the district nurses with regard to informal meetings with other practitioners.

Ex.2.34

*Janet: I think if we worked closer together with them then I think communication would be easier. Perhaps even looking at if we all worked in the same office, covering the same area and then you've got OTs and physios and dieticians and social workers all involved in the same service. I think perhaps looking at that would be useful. There's one rehab team for South Spilsdale, there's one adult care, elderly person's team. We do meet every week, we do meet and we go over clients we have together, but you get better communication if it's less formal and if you work together and you can informally chat about patients. That's the best way.*

(Social care assessor team leader: South Wigglesworth team)

It was felt that by working in close proximity to each other, communication would improve through the contact that comes from informal chats or practitioners 'dropping by' to discuss events. Furthermore, both district nurses and social care staff pointed out that attending meetings was difficult because of the increasing pressures of work. Therefore it became apparent to me that working in close proximity would not only help them to understand the roles of other practitioners but would save them time in traveling to meetings.

## **Discussion**

I have pointed out in the findings that the conversations about the development of the district nursing service brought to the fore professional identity and boundary issues, in particular; how practitioners negotiated their roles in their daily work, and how they responded to the changes that they were experiencing. To inform our understanding of the dilemmas of identity and change I have largely drawn upon Kelly's corollary of experience and choice (1955, 1967). Also, I found the concepts of 'loosening' and 'tightening' constructs (Kelly, 1955, 1991) useful in developing ways to facilitate practitioners in adapting to change.

### **Coping with change**

It was notable that the practitioners had a tendency to raise concerns about the broader national changes that had taken place; especially, the implementation of the Community Care Act (1990). Overall, some practitioners appeared to feel very strongly about the changes they were experiencing, and were active in their opposition to the way they were treated. In contrast there were those who did not appear to actively oppose the changes they were experiencing. They may have felt uncertain about what the changes meant for them, but were resigned to them anyway. Also, there were other practitioners who felt change was something that had to be adjusted to, and which they had no control over, however they felt personally. Interestingly, those district nurses who appeared resigned to the changes were the ones who had reported feelings of increasing isolation from their peer group and other professional groups (Ex.2.33. p.223).

Overall, from the findings I would contend that how practitioners responded to the impending changes was largely influenced by the following: first, the personal constructs they had assigned to their roles, and how important these were to their sense of identity; second, how their changing roles of roles were recognised and accepted by the public and other practitioners; and finally, the degree to which the organisational structures facilitated or hindered change. I will now discuss these aspects in turn.

#### **i. Construing role**

For many district nurses, delivering and supervising personal care were seen as key to the nurse's role, and many practitioners were reluctant to leave these practices behind. The findings revealed that the pressure to relinquish key aspects of their work left some practitioners feeling that their roles had been 'eroded', or that they had been 'squeezed out'. Others were happy to leave these aspects of care behind to move onto what they felt were more exciting and challenging aspects to nursing. Relinquishing personal care did not apparently impact greatly on their overall sense of professional identity. Therefore, they were happy with the devolvement of personal care, as this enabled them to take on new challenges, and seize new opportunities to extend their technical and managerial skills.

I would like to add a further thought. Because of the increasing expectations, and demands made upon community services, more service developments may be construed by practitioners as increasing their workload to an intolerable degree. Therefore, staff

may be reluctant or resistant to extending their roles if they have to fill the gaps for other services.

## **ii. Visibility and recognition**

The previous study highlighted how recognition and visibility of role was important for practitioners' sense of identity and how they negotiated care with other practitioners. It follows where a service is virtually unseen or hidden, there may be a lack of understanding by other services, and poor communication with them. For instance, the OHDNS was a service that was virtually invisible to some staff groups, in particular the medical and ward nursing staff. In response to some of the changes the OHDNS were experiencing, they promoted an awareness of their service and the district nurse role to other practitioners. Additionally, by placing themselves in new situations with other staff members, they gave themselves the opportunity to engage in new relationships and different ways of working.

Likewise some of the social care staff also felt unrecognised for their skills, not because they themselves were unseen, but because their skills were unseen and hence undervalued. They perceived that others did not recognise their areas of expertise, because these were not seen as specialties. Therefore, they felt they had become the 'dumping ground' for aspects of work that others did not want to do (see Ex. 2.16. p.212). Furthermore, if their work was recognised this would have repercussions in terms of increased financial input and being able to develop professionally (see Ex.2.18. p.213).

One of the most effective ways of enhancing visibility and recognition is through meeting other practitioners. However, from the findings it was found that regular meetings with other practitioners were not sufficient to promote awareness and understanding of each other's roles. There were regular organised meetings where problems were discussed and where care arrangements between the two services could be finalised. But, for developing relationships between the different practitioners, many commented how they preferred the informal contact with staff, which came from working on or near practice bases. Informal meetings tended to develop an openness and mutual trust between staff groups that formal or planned meetings did not. This has been highlighted in earlier studies where communication and relationships between professions improved when social workers were located on the same base as health staff (Glendinning, Rummery and Clarke, 1998).

### **iii. Organisational influences**

The student study highlighted the difficulties some people experienced when they wanted to reconstruct their roles or work flexibly with others. For example, the way social work is financed or structured tended to constrain social workers from responding to clients as swiftly as district nurses. Notably, the findings from this study have brought to my attention how the location of work may have important implications upon inter-professional relationships. First, the findings suggested that some of the recent re-organisation of services (both nationally and locally) had created a distance between practitioners; both geographically, and in terms of their professional relationships. For instance, the relocation of social service bases to central offices created a geographical

distance between district nurse practices and social work bases. Consequently, this led to relationships becoming more distant than before, because the casual meetings between district nurses and social care workers in the course of their duties were no longer possible. Arguably, a physical distance between staff groups encourages the perception of separate occupational identities, with different interests and aims.

Second, the findings illustrated how the Acute NHS Trust had failed to understand the way district nurses worked and the importance of their working environment was to their role and their identity. For instance, the OHDNS Central team felt their relocation to the hospital OPD meant that they lacked the essential facilities to enable them to work as district nurses. This led to further tensions between district nursing and hospital staff, which perhaps could have been avoided (p.196- 198, p.120).

### **Adjusting to change**

So far I have described the ways that people are influenced by interacting with others, by their professional training and by their practices and procedures of their chosen profession. Therefore, can practitioners consciously and deliberately change the way they practice? Earlier authors have contended that members of established professional groups cannot be expected to abandon their old ways (Rawson, 1994). It is argued that the methods of practice are so deeply embedded in the occupational culture that they are virtually impossible to change. This gives us a picture of a rather inflexible and constrained practitioner who is unable to modify their outlook, and who will resist change at all costs. On the contrary, from a constructivist phenomenological viewpoint, I would argue that people are not totally shaped by their past, but are in action with their

environment. This means that their constructs are constantly evolving. For instance, there are times when we are exposed to new experiences and we find that yesterday's ways of construing are no longer useful for anticipating today's events (Kelly, 1955). Consequently, there are times when we search for new information and a revision of our constructs to adjust to the changes we are experiencing.

However, there are people who have more difficulty than others in modifying the way they construe their work or their world. According to Kelly this largely depends upon the choices they make and the impact these choices have upon their construct system. Kelly describes the predicament of choice in terms of whether the individual will broaden their construct system, or choose ways of thinking that will further support their 'old' constructs.

*' which shall a man (sic) choose, security or adventure? Shall he choose that which leads to immediate certainty or shall he choose that which may eventually give him wider understanding?'* (Kelly, 1955 p. 64).

Furthermore, the impact of change may be perceived as threatening to the individual if we are aware of '*imminent comprehensive change in one's core structures*' (Kelly, 1955 p.489). To reiterate, I mentioned earlier (Chapter 2) that we have a highly organised personal construct system, structured according to how important constructs are to our sense of identity and way of being. Kelly goes onto argue if we are to take on board new experiences and new adventures our superordinate constructs need to be permeable. In contrast an impermeable construct is defined as a rigid way of thinking and

*'one which is based upon a specified context and which will admit no additional elements'* (p156).

This creates a dilemma for the individual. On the one hand if we are unwilling (or do not know how) to embrace new ideas we are *'limited to a more or less footless shuffling of old ideas'* (p. 487). On the other hand, embracing new ideas may be viewed as incompatible with our core constructs and may mean a change to our whole way of construing upon which we depend.

So how does this help us to understand these findings? In a changing world of health and social care, familiar pathways of thinking and acting provide a sense of certainty and predictability for the practitioner. Also, for some practitioners certain ways of working have become core structures, from which they have maintained their professional identity. Therefore, pressure to change superordinate constructs, or numerous changes in quick succession, may be perceived as threatening and may result in individuals withdrawing into already established ways of working. Consequently it is not surprising that practitioners may be unwilling to explore new ways of working or resist further changes, as they *'claw frantically for their basic constructs'* (Kelly, 1955, p.167). For instance, some district nurses (OHDNS-central team) perceived their working environment as an essential part of the *'efficient'* way they worked and acted as a nurse. Consequently, *'imminent and comprehensive change'* to their working environment might be perceived as working in a disorganised and time consuming way, which is incompatible to how they perceive their role.

In contrast, some practitioners may be keen to choose adventure and to take on new challenges, as this may not affect their core structures of what it means to be a particular professional. For example, there were staff groups in this study who were keen to 'extend' their roles (see p.210) and perhaps it can be said here their 'caring' construct was more permeable than those who perceived their roles as eroding. However, in practice changes to roles may mean an increasing workload, which staff feel they cannot support. In this way firm professional boundaries, where roles are clearly defined and rigidly adhered to, may be seen by practitioners as a useful counterbalance to unwanted extra work, or too much change within a relatively short period of time.

### **Re-construing constructs**

To consider how people reconstrue their ways of thinking and how this may be facilitated I will turn to another area of Kelly's work. Personal construct theory was developed as part of clinical psychotherapy and provides a useful tool in helping people to consider new ways of construing, and to embrace new ways of working. Kelly proposed a number of techniques, which encouraged the person to 'loosen' and 'tighten' constructs. Put simply loosening is a way of facilitating people into releasing new ways of thinking, so they are amenable to the extension of their constructs. A loose construct might be an abstract idea or image, such as one may find in daydreaming. These thoughts are then harnessed, or 'tightened', so that they may be tested and applied to practice (Kelly, 1991). Ideally then, the way a person may adjust to change is for their constructs to be permeable enough to embrace a new outlook, but 'tight' enough to make their ideas practically meaningful.

### **Facilitating reconstruction**

To apply this to practice, one of the principles that Kelly suggests is to provide a non-threatening and non-critical context. For practitioners the context would ideally be outside their personal working environment, either in a one to one relationship as one would find in mentoring or a small, familiar group where a sense of trust and openness may develop. Whatever the situation, it is important to promote an environment where practitioners may feel accepted and their contributions validated.

Since we develop our constructs in action it is important that we provide a forum where people are actively participating and negotiating with others. From my experiences and findings from this study I suggest the following. First, within workshops one may utilise a number of techniques, which will challenge 'old' ways of thinking and encourage practitioners to reflect upon their practice in new ways. This may include exercises to help a practitioner to place their own knowledge to one side in order to explore creative thinking. Then, the role play activities might follow, where practitioners playfully experiment with different practical applications of their 'loose' constructs.

Secondly, people may not be able to conceive different approaches to working unless they are exposed to a new environment and working with other people who are operating in different ways. This may be arranged by enabling practitioners to 'shadow' clinicians in other areas, and even in other hospital trusts. This will not only encourage working relationships but will give the practitioner a greater understanding of how other practitioners work.

Thirdly, another exercise that may encourage practitioners to reflect upon their work in different ways is an interview technique used for studying interpersonal relationships (Hargreaves, 1979, Salmon, 2003). This is usually performed as an individual in the presence of a facilitator. I found it particularly useful in helping practitioners to consider different ways of relating to other practitioners, and to help them express their pre-reflective activities. I have utilised and adapted this tool for interviewing practitioners and this is described in detail in the following chapter.

### **Re-construing resistance to change**

I have largely focused upon the practitioners' responses to change, and how to facilitate those who may be resistant to new ways of working. It is beneficial at this point to consider how policy makers and managers may reconstrue ideas about practitioners' resistance to change. Looking at earlier organisational literature, resistance to change is often presented as a negative experience, and something that should be managed or avoided (Hornby and Atkins 2000). But I would argue in support of King (2003) that resistance may act as a 'counter balance to the dramatic changes' experienced. I would go further and argue in the case of the OHDNS, resistance was a positive experience and encouraged the district nurses into action in the following ways. First it brought together the OHDNS staff, who supported each other in team actions, and second the resistance prompted negotiations with other practitioners and Trust managers. Their resistance perhaps may have made little difference to the timing of events and the eventual outcome, but in resisting they had made themselves visible to acute staff and management. In so

doing, they sought to express their group identity by actively publicising their abilities and negotiating their roles with staff on the wards.

## Summary

To conclude, discussions about the recent service developments with staff groups brought to the fore both national and local changes. Boundary issues between disciplines were highlighted, and problems and difficulties once tolerated were now a matter of concern. The pressure to change particularly highlighted professional values and the way practitioners construed their occupational identity. Change can be beneficial, as it encourages practitioners to rethink their practice and their relationships (Pietroni and Pietroni, 1996): but too many rapid changes may force professionals to revert to established ways of working and existing constructs (Kelly, 1955).

Clearly defined professional boundaries were found to be particularly useful for protecting practitioners against both unwanted work, and an increasing workload, when working with other disciplines or negotiating joint working. For instance, a social care worker implied that their field of work would not have become a 'dumping ground if they were a specialty' (Ex.2.16, p 212). Having a 'speciality' meant there were clearly defined boundaries within which practitioners could manage their work, and gain a sense of autonomy over the way they worked.

The perceived need for clearly defined boundaries is perhaps problematic with the demand for a flexible multi-skilled worker, and the emphasis upon collaborative working

(D.O.H, 2001a). It is essential in contemporary practice that professional boundaries become pliable in order to explore new methods, new ideas and new ways of working. Therefore practitioners need to be given the opportunity to explore new ways of construing their roles and joint working, in an environment where they may develop trust, mutual understanding and support across their usual working boundaries.

Drawing upon Kelly's work was useful in furthering our understanding of how people construe change and adjust to changes that may be taking place within their workplace. Furthermore, resistance to change may be reconstrued as a useful mechanism in the process of change.

I am aware that my method of data collection may have exaggerated some of the points raised within the study. It may be argued that the use of focus groups emphasized the group identity and the differences between groups, whereas through the use of individual interviews differences may have not been so apparent. On the contrary, I found that in my early individual interviews, the students were just as keen to identify the differences! So why use focus groups? Certainly from my focus group experiences I gained an insight into the groups' feelings, their sense of nostalgia and perhaps the memories of 'better' days that were not easily accessed in a one to one interview. I would also argue then the volatile characteristics of focus groups enhanced the study by counterbalancing the relatively composed nature of individual interviews, where participants are perhaps reticent about expressing their feelings. However, I acknowledge that one can gain a depth from individual interviews, which is perhaps not so obtainable from focus groups. For example, through focus groups I could not ascertain how practitioners negotiated

their professional relationships on a day- to-day basis within their working environment. The majority of district nurse and social care work takes place within small teams, and negotiation between disciplines often takes place on an individual level. Therefore in the next and final study I will explore in closer detail the interdisciplinary relationships that may arise during the care of an individual client. I will focus upon the individual practitioners: how they see themselves, how they see their overall relationships in a given situation, and how they involve themselves in a 'project' not as an onlooker but as being in that world.

## **Chapter 9.**

### **Study Three: Inter-professional constructs and networks.**

#### **Part one: Methodology and interactive interviewing**

The previous chapter largely focused upon a particular district nursing service and its relationships with social services during a period of change. The study illustrated how organisational change may strengthen a sense of group identity and unity and at the same time encourage the district nurses to make other practitioners aware of their skills roles and contributions to care. However, the different responses towards organisational change highlighted that practitioners may construe their role in quite individual ways. From the focus groups it is evident that the majority of work takes place within small teams and negotiation between disciplines often takes place on an individual level. For this reason I have sought to explore further how individual practitioners may construe their identity and relationships as they go about their work.

Therefore the aims of this study will focus upon the individual district nurses and social care staff within the district of Spilsdale; how they view themselves and their relationships in a joint working situation, and how they negotiate their roles on a day-to-day basis within their practice. This chapter will discuss the methodology and will present two case studies to illustrate the benefits of a particular interactive style of interviewing. The overall findings and discussion for this study will follow in the next chapter.

## Methodology

One effective method of collecting data, which I utilised earlier, was in-depth, semi-structured interviewing techniques. From a constructivist phenomenological position this has been found to be useful way of eliciting constructions (Leitner, 1985, Burr and Butt, 1997), whereby the person is encouraged to describe their perspective and then prompted to elaborate on events. However, at times it is difficult to articulate how one feels or how one interacts with another person. Earlier I argued that many of our constructs are pre-reflective and have no symbols or word handles (Kelly, 1963, Merleau-Ponty 1962) and often are expressed in action; for example, our bodily gestures and stance during a conversation (Butt, 1998). Often it is only when people are experiencing difficulties with others that they will reflect and consider how their relationships and communication with others may be improved. It is possible when it comes to interviewing practitioners concerning their inter-professional relationships there may be immense problems separating practitioners' everyday experience from their theoretical or professional knowledge.

During my earlier interviews with student practitioners (Chapter 5) there were times when it was difficult to access their everyday experiences, their feelings, and how they interacted with others. I felt I had gained an insight into their professional values and doctrines they had taken on board through their training, but it was difficult to separate this from their experiential knowledge. For example, when I asked students, 'How do you see the role of a district nurse?' I would be presented with a list of textbook definitions, or they stumbled for words to describe their experience. Many of the students

had seen the work of practitioners, but it was difficult for them to articulate their impressions outside the work context in an interview situation.

To solve this research problem I wanted something that would engage the practitioners, as well as something that would uncover what it means for an individual to be a particular practitioner- a 'being amongst others'. In my search I was directed to methods used in personal construct psychology for exploring social networks (Hargreaves, 1979), and changing relationships (the 'Salmon Line'-Salmon 2003, 1984). I then adapted these interview techniques to help the participants to describe and reflect upon an everyday joint working event.

### **Interview techniques**

There were two phases to the interview. First, I utilise Hargreaves' social network method (1979) to elicit an account from participants of the people they interact with in a given situation, and how they perceive their working relationships. Therefore, participants were asked to reflect upon a working scenario of their own choice, which involved other health and social care professionals. For instance this could be a current or a recent event involving a long-term care of an elderly patient in the community. They were then asked to write the names or job titles of those involved in their chosen scenario upon arrow shaped cards (including their own names). These they place upon a large sheet of paper in whatever pattern they felt described their working relationships. For those participants who required further prompting in organising their pattern, it was suggested that they could use the proximity of the cards to indicate closeness of

relationships, and the position of the arrow to indicate the direction of their relationship. For example the arrow pointing away from a particular person indicated that their relationship with that person was becoming more distant.

Once they were clear on the task I would leave the room for 10 minutes to give them time to reflect and to prevent further discussion during the process. On my return, and once they had finished organising the pattern, I would trace round the cards onto the paper for a permanent record. Then I invited them to describe their situation and explain the position of the cards. For example, I would ask 'Why have you placed this card here and those there?' I might add that the interpersonal networks were not designed as an observational method to identify the frequency of interactions, but rather to identify from the participants viewpoint who they interacted with in a given situation, and how they perceived their working relationships.

The second stage involved the 'Salmon Line', a technique developed by Phil Salmon (2003, 1994) to help people focus on how change may be achieved. From the discussion of the visual layout, the participant and myself, selected what is known in construct psychology as a 'bipolar construct' (Kelly, 1955). Examples of such constructs could be 'friendly-unfriendly', 'good communication-poor communication', or 'helpful-obstructive'. The choice of construct was drawn from important themes that emerged from our discussion. On the back of the paper a horizontal (dimensional) line was drawn between the poles of the chosen construct, for example:

'Daily contact'-----'no contact'.

They were then asked to place the arrow-shaped cards along the line in relation to others. Again I traced around the cards onto the paper for reference during the interview, and for later analysis. I then asked the participants to give reasons for their card positions, their ideal positions, and how they might facilitate improvement in their relationships - indicated by the way they moved arrow-shaped cards towards the desired pole of the Salmon Line. The benefit of this technique is that the card positions are not necessarily fixed and can be moved around during the course of our discussion, as alternative strategies and possibilities are considered.

### **Sampling**

For the final stage of the research, I focused upon practitioners who held a similar managerial level of practice within their respective organisations and who had experience of working with other disciplines within the community. They included home care managers, social care assessors and qualified district nurses. To include the variation of practice within the region I aimed to choose practitioners who were working from different teams across the region, i.e., practices that were based within Central Wigglesworth, Upper and Lower Spilsdale valley. I intended to keep the sample size small, with a maximum of eight participants to allow for an in-depth analysis. However, the sample size would ultimately depend upon the access to participants, the variation of experience, and the quality of the interviews.

### **Negotiating access**

I had maintained contact with the different district nurse teams and social service bases through the organisation of focus groups for the local service evaluation. Access to individual participants required a slightly different approach depending upon the service.

With the district nurses I had already gained overall permission from the senior community manager to evaluate the district nursing service, as well as to gain access to staff for my own research. Also, I had access to a list of district nurses and the contact numbers for their team bases. The district nurses are the team leaders or senior team members of a district nurse practice and therefore, I could ask them directly whether they would wish to participate in individual interviews. From the focus groups of the previous study I had drawn up a small list of contacts from the teams across the district who were willing to talk to me about their work and joint working relationships. In the final outcome I was able to contact three district nurses, one from each of the three localities; Central Wigglesworth, the Upper Valley and Lower Valley. My experience of arranging focus groups with district nurses had shown that the most efficient way of arranging interviews was by telephone. I was able to make direct contact with specific individuals and have a swift response to my request. Also, I was able to discuss the purpose and design of the interview and arrange a mutually suitable time to meet.

The process of gaining access to social care staff was more complex than the district nurses because of the way they organised their services and managed their time. Permission from the community nursing manager did not 'automatically' extend to

Social Services. I had initially contacted Social Services when evaluating the district nursing service. At the time they were prepared to co-operate with the health service in an evaluation, but I was unsure whether their willingness to participate in interviews would extend to a postgraduate research project. Another difficulty was that social care services consisted of two parallel structures (as I mentioned earlier in chapter 4) - the social care assessors and the home care managers. These were managed independently of each other and were often located on separate sites.

To access the social care assessors meant that I needed to gain permission from a senior manager who would agree to release members of their social care staff. This required a letter giving a description of the aims of research, the format of the interview and what I intended to do with the data. With this letter I enclosed a small form (see Appendix, p.355 and p.359) that requested names, staff grades, contact numbers and availability. Those who wished to be included placed their names on the form, which was then forwarded to my office. In accordance with my research aims and the sampling criteria I selected two senior practitioners - one from the Upper Valley, and the other from the Central Wigglesworth.

Accessing homecare managers was a similar process to accessing the district nurses, in that I made direct telephone contact to the appropriate base. In this instance I selected the Upper Valley home care base. The home care manager there was already familiar with the research work from the previous study and was willing to take part in this particular stage of the research.

## Introducing the participants

The final sample group consisted of six participants. Below I have given brief character summaries of the selected participants outlining their experience and current responsibilities.

- 1. Maxine** is a 33-year-old female who for nine years has worked as a district nurse in the rural Lower Valley of Spilsdale. Initially she trained in a university south of the region. Currently she is based in a GP practice near Mistlethwaite town and is responsible for the GP's caseload. Maxine is a team leader within the practice where she shares her job working three days a week with another district nurse. Her particular expertise lies in wound care and she manages a leg ulcer clinic once a week.
- 2. Claire** is a 39-year-old district nurse coordinator who is currently managing a busy district nursing team in the centre of Wigglesworth. Alongside her district nurse work she has been working as an 'intermediate care manager' within a multidisciplinary team at the Royal Spilsdale Hospital. She was trained in a metropolitan city east of the region and has since worked within the Spilsdale area for the last six years. Claire also holds a diploma in mentorship, which enables her to mentor trainee district nurses.
- 3. Wendy** is 47 years of age and qualified a year ago as a district nurse at the local Houghton University. Although relatively new to the post of district nurse, she

has worked both in the community and on the hospital wards in Spilsdale for the last twenty-one years. She was a ward sister for many years before moving to a district nurse liaison post within the hospital. During her time as district nurse liaison she undertook part-time district nurse training. She is currently working as a district nurse in a GP practice within the Upper Valley of Spilsdale, close to Wigglesworth.

4. **David** is a 38-year-old senior practitioner and social care assessor for the adult care team based in the offices at Mistlethwaite town. This office largely covers the Lower Valley region. David is a qualified social worker and has worked for ten years as a generic worker in the Youth section of the social services. Following structural changes to the Social Service in 1993 (the purchaser-provider split), he moved to adult care. Currently, he is responsible for complex social care cases and oversees a small group of care coordinators and assistants.
  
5. **Natalie** is 48 years old and is a senior practitioner for adult care. Like David she oversees a team of social care coordinators and is responsible for complex cases within the central region of Wigglesworth. Prior to social work, Natalie has worked in the health service and in community care. She trained as a social worker in 1994, and then worked in childcare for six years before taking a post in adult care. She has gained a degree in social sciences through a distance-learning programme, and now takes a special interest in the care of the elderly and adults with learning disabilities.

6. **Debbie** is 52 years of age and is one of the home care managers for the Upper Valley region. She is also responsible for the out of hours home care service and for the training of manual handling. She had worked in home care for many years prior to the restructuring of the service. Unlike the two senior care practitioners she is not a qualified social worker. Before her experience in home care she worked in the housing department of Social Services for ten years and gained a management qualification (C.M.S.) from a local university.

## **The interview experience**

I felt privileged that the practitioners were willing to give up their time, and therefore arranged the interviews at the convenience of the participants. Often this was when there was a lull between their client cases or in their own 'free time'. They were informed that the interview might be a lengthy process, depending on how they utilized the experience, and that it was essential to go to a quiet and comfortable place where we would not be disturbed.

### **Location**

The interviews took place within the practitioners' working environments rather than my office, because such surroundings were more likely to encourage practitioners to disclose their personal opinions and feelings about their work. I interviewed social care practitioners and the home care manager in their office bases, usually in the department's meeting rooms. This was particularly useful as we were able to find tables large enough to spread out the large sheets of paper used for the reflective layouts.

For two of the district nurses, we were not able to use the practice office, so the interviews took place within my home and a district nurse's home close to their practice base. Interestingly, the interviews with the district nurses were particularly informal as the nurses presented their networks upon the floor, as there were no tables large enough to contain the layout. Any potential barriers that might have arisen between myself and the district nurses were overcome by this relaxed setting.

## **The Scenarios**

There seemed to be no difficulties for the participants deciding which situation to present on the network layout. Usually the scenarios were current or very recent cases they had been involved with. Often the chosen case scenario was a complex, multidisciplinary situation that demonstrated a range of relationships across health and social services. I was concerned that the participants had chosen these scenarios because they were unusual, and therefore would not reflect the average, day-to-day events. However, I was informed by the practitioners themselves that there were an increasing number of complex scenarios appearing within the community, and many people had a number of needs that required the input of many different services.

To illustrate the usefulness and flexibility of this interview technique I will now briefly present two case studies, Maxine and David. I have preserved the anonymity of the participants and their patients by replacing the personal and place names with pseudonyms.

## **Case studies**

### **1. District nurse: Maxine**

The interview took place one afternoon in the staff room of a general practice where Maxine worked. She had chosen a fairly quiet period in the day of the practice so we would not be disturbed.

### **The scenario**

Following the introduction to the purpose and explanation of the reflective exercise. I issued Maxine with 12 arrow-shaped cards and a large sheet of paper, and left her for 10 minutes whilst she decided upon a joint working scenario. Upon my return, Maxine was seated on the floor and was well into organizing her pattern of relationships. I sat with Maxine on the floor whilst she enthusiastically explained the people involved in her case scenario, adding cards to the growing design (See fig 3.1 overleaf). Practitioner's roles and relationships that I didn't understand I was able to ask for further clarification. For instance, by pointing to a card I was able to say 'Who is this, and what does this person do?'

The scenario Maxine had chosen was a highly complex dependent case, which involved many services. The patient was a man with multiple sclerosis and diabetes, who for anonymity we have called Ray. Ray was paralyzed, immobile, incontinent, and required assistance for all his personal care. The home care services were involved in providing the personal hygiene care of day-to-day living, and the district nurses were there to monitor the diabetes and to ensure there were no complications as a result of his immobility.

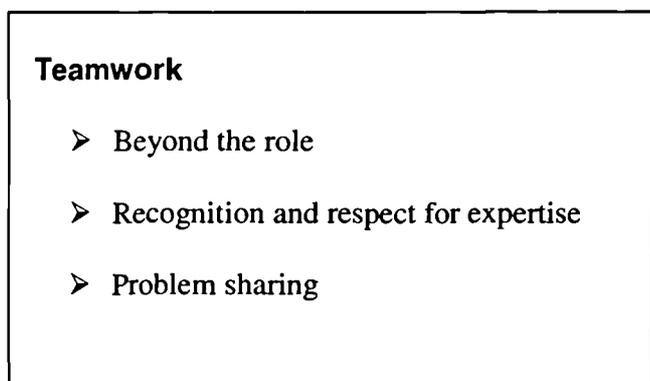
After she had finished her descriptions and explanations of the scenario, I turned the sheet of paper over and drew a horizontal line. From our conversation we decided to assign 'poor joint working' at one end of the line, and 'good joint working' at the other. Maxine then placed her arrow-cards along the dimensional line according to how well she worked

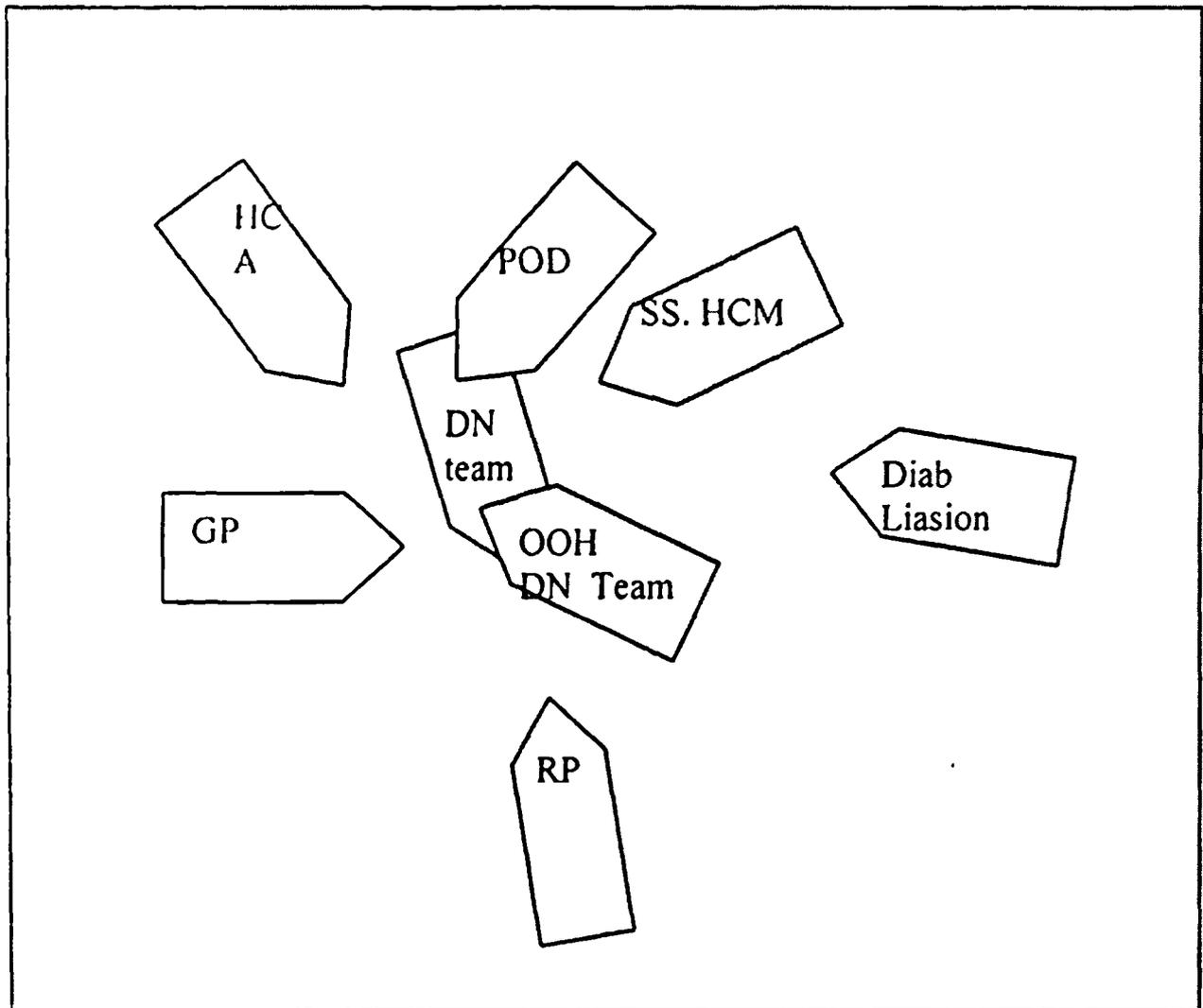
with others. (See fig 16). Again I invited her to explain the reasons for her card positions, and asked her how she could improve some of her relationships.

## **Analysis**

The exercise was taped, transcribed verbatim, and analysed using the template analysis approach (as described in previous studies). For the purpose of this illustration I have taken examples from the broad theme of teamwork, listed below.

**Fig 14. Template analysis: Maxine**





**Figure 15. Maxine's inter-professional layout**

DN: District nurse team

OOHDN: Out of Hours district nurse team

POD: Podiatrist

HCM: Home care manager (Social services)

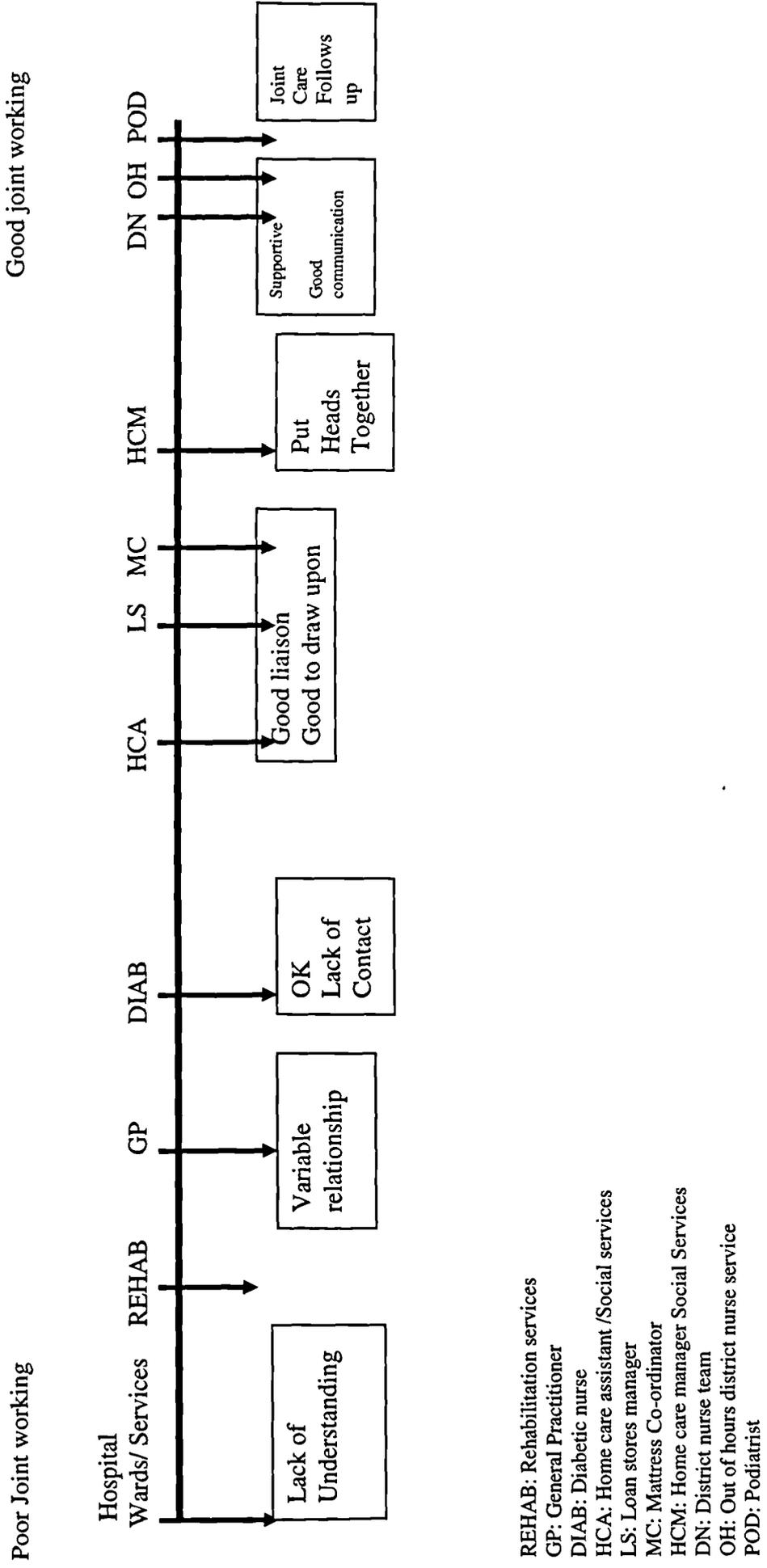
HCA: Home care assistant (Social services)

Diab Liaison: Diabetic Liaison Nurse (Specialist hospital nurse)

GP: General Practitioner (family doctor)

RP: Rehabilitation/Physiotherapy team

**Figure 16. Maxine's Salmon Line**



## Findings

### Teamwork

From the data it was clear that teamwork was very important to Maxine. She was very keen to be seen as part of a team. This may be partly attributed to her job sharing, as she is reliant on the others within the team to continue her role. Note on the layout she does not include herself as an individual but as part of the district nurse team.

#### Ex.3.1

*The most important thing is keeping good relations going and trying to understand each other's commitments and trying not to get into that way - 'this is my role' and 'this is your role'. We are working as a team. We need to go as a team and I've been in a team, which I feel I am very much (part of); the social services podiatry and sort of rehab specialist nurses. We always go (to assess) together.*

In spite of working in the same practice and being in constant touch with the GPs, she regards herself as not having the same team work relationship with them as with her district nurse colleagues.

#### Ex.3.2

*With GPs we are working hard (to develop a team relationship), for the last 9 years we have been working. We never seem as a proper team, they are not a team are they?*

So how does she define good working team relationships? In what ways was it not working here? Let us look at how she describes her 'good' relationships, and what 'good' team work means to her.

### **Beyond the role**

The first example describes a closeness of working together where boundaries between roles begin to blur. Those with whom she works very well are those in one sense willing to go 'the extra mile', those who are willing to cross their job roles or boundaries and respond swiftly to the situation. The example here is referring to the home care manager.

Ex.3.3

*Adam went in on the Monday morning to move his (the patient's) bed out so the hospital bed could be delivered and put straight in. If you haven't got a social worker who works well with you like that the whole thing falls apart! I don't think it's really his job to go and move a bed out of the way – there isn't anyone else out there!*

Going that extra mile and showing commitment also means to Maxine giving up personal time. She went on to explain how both she and the podiatrist were willing to give up personal time to miss a Christmas party, in order to respond to a client; if you notice, the podiatrist is high on the dimensional line of working well. Response time is also important to Maxine; she would rather '*miss her lunch than think of patients going all night if there was a problem*'.

### **Recognition and respect for expertise**

Other relationships which she held in high regard, were with the mattress coordinator and the loan stores manager. Maxine describes herself as having a '*fantastic*' relationship

with the mattress coordinator. Here she values the mattress coordinator's knowledge and expertise in sorting out her problems.

Ex.3.4

*The mattress coordinator, she is worth her weight in gold, we work fantastic together. Yeah I'll say, 'I've got a problem with a pressure sore, have you got anything?' - If she doesn't know it I know its not available.*

The final example below illustrates the meaning and benefits of good teamwork for Maxine. Here she highlights the contrasting experiences of the acute services and social workers.

### **Problem sharing**

As a result of her regular meetings with Social Services she has developed what she calls a closer relationship and understanding, where they share each other's demands and problems at the meetings.

Ex.3.5

*They (social services) tell us what the demands have been put on their services and what the latest thing they have been told, what they can do and can't do, and we let them know what the demands and what the problems we're having.*

This is in contrast to the acute services where she describes little contact with staff, and poor communication between wards and the community; hence a lack of problem sharing, and little understanding of each other's roles. Furthermore she feels that hospital

staff lack understanding in how patients are managed in the community, and believes that the staff concerns do not go beyond the ward. Maxine went onto say how she would be the one to ring the ward for more details of a patient, or to try and explain to ward staff about the awkwardness of Friday afternoon discharges. She told me that these late Friday afternoon discharges did not give community staff time to coordinate their services for the patients.

Through the Salmon Line she was able to consider some new ways of resolving the difficulties she was experiencing with the ward staff, such as 'adopting a ward' and making regular visits to it. By visiting wards, she felt she would give the hospital staff and herself the opportunity to get to know each other, and to begin to appreciate the different ways that they worked.

## **2. Senior practitioner, social care assessor : David**

I met David one afternoon at the Social Service offices in Mistlethwaite town. He booked us the team meeting room so we were able to use the large tables to present the layouts. In the same way as the previous interview I explained the purpose and reflective task to David. I then issued him with arrow-shaped cards and a large sheet of paper, and left the room for about 10 minutes. Like Maxine, upon my return he was well into the design of his layout.

## Scenario

David had also chosen a complex, on-going case, which involved a number of different services (See fig 18) looking after an elderly couple; Mr and Mrs Stamford. The social services have been helping this couple for about five years. Mr Stamford was an 88-year-old gentleman who was suffering from diabetes, dementia and 'low grade' Parkinson's Disease. Mrs Stamford was 82 years of age and was his main carer. She was described as an anxious lady who did not like the intrusion of social services into her home. She refused many of the services that were offered to her and at first David was not invited inside the house when he visited. His visits largely consisted of talking to Mrs Stamford on the doorstep. At the time of the interview David had begun to develop a relationship with the couple through the help of the district nurses who were visiting to monitor Mr Stamford's diabetes. There were concerns about Mrs Stamford's ability to look after Mr Stamford, and the condition of their home. Over time David has managed to persuade Mrs Stamford to have equipment installed into her house such as a high backed chair, a commode, and home help with emptying the commode. He is hoping that they can develop their relationships to the point where she will accept home care to attend to aspects of Mr Stamford's care.

David designed his layout pattern around the relationship Mr and Mrs Stamford had with the different practitioners involved in their care. From this I was able to gain an overall picture of the complex way the different services combined to provide care for this couple. Following our discussion of the layout I turned over the paper and drew the dimensional line. In this case David largely based his descriptions of good working

relationships upon how well they communicated with each other and attitudes towards each other.

## **Analysis**

Using the template analysis I identified the following themes concerning David's constructs about teamwork.

**Fig. 17 Template analysis: David**

<b>Teamwork</b>
Working alongside vs. 'out in the wings'
Open mindedness
Flexibility
Recognition and respect for expertise
Back and forth communication

**Fig.18 David: Inter-professional Relationships Reflective layout**

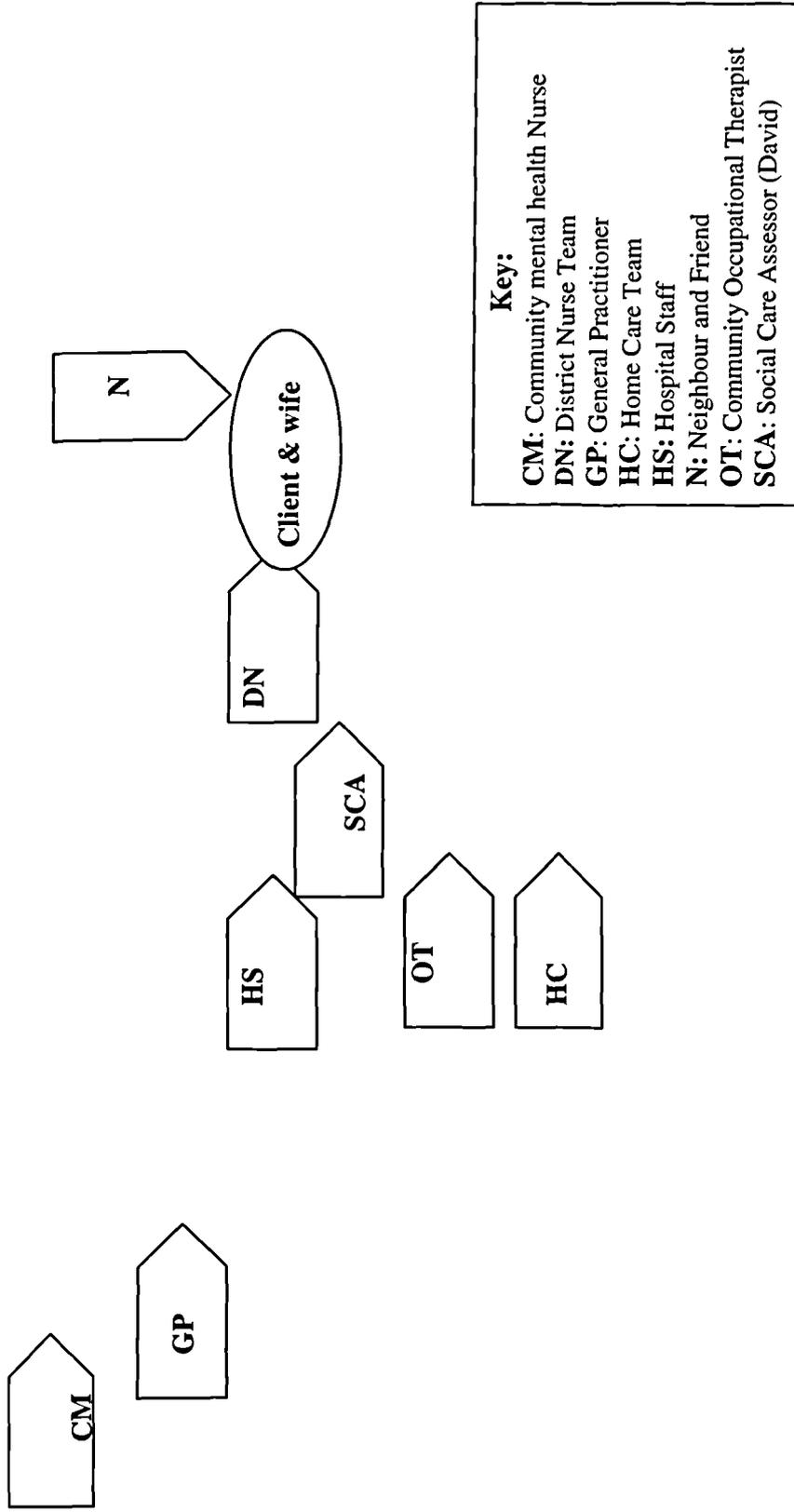
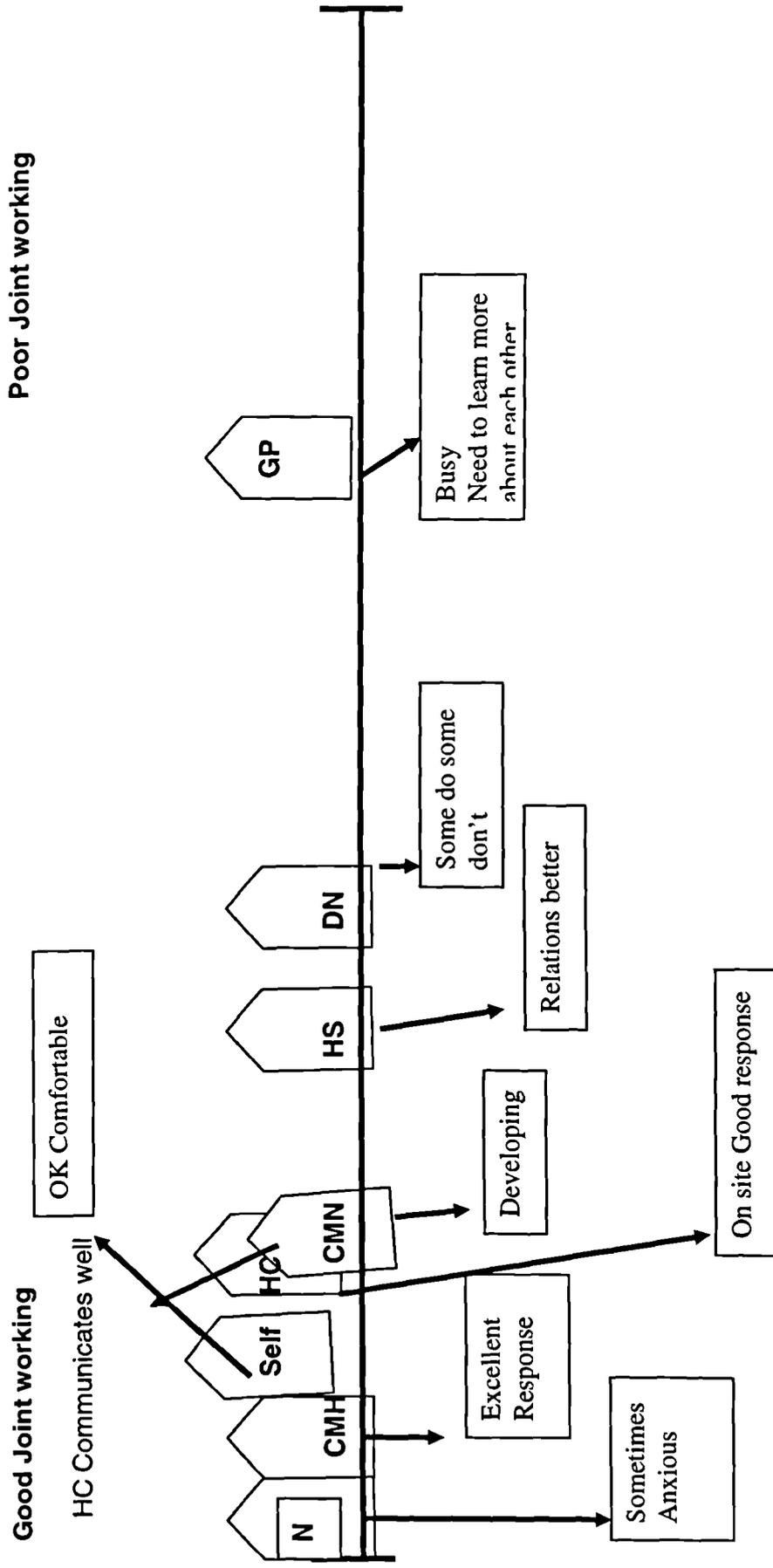


Fig. 19 David: Salmon Line



## Findings

### Team work

In contrast with Maxine, David did not particularly describe his relationship with others as a team. In this case he described the relationships as a working alongside the district nurses, as a *'waiting in the wings'*. This was largely attributed to Mrs Stamford's mistrust of other practitioners. Like Maxine, David described the GP as someone who kept their distance and did not get involved. Again he attributed this to the 'nature' of this case.

Ex 3.6

*The GP has been involved but I think he refers to us a bit reluctant, because maybe he feels it's a bit of a crisis situation, which is more of a social care problem than medical even though district nurses are the key players. So he is kind of kept his distance apart from going into check him (Mr Stamford) medically when he's been poorly.*

Along with other comments, David implied that there was a reluctance by GPs to get involved with social care problems and social workers. This was further highlighted when he described some joint meetings that he had attended where GPs were present, in contrast to joint meetings with other practitioners he had worked with. So what are the characteristics of good working relationships for David?

### Open-minded

For David, 'open-mindedness' played an important role in maintaining good joint working relationships. This concept seemed to emerge a number of times during the

course of our discussions, and usually accompanied those whom he had particularly good working relationships with. For example, it was notable that the OT was high on the dimensional line (see Fig.19).

Ex.3.7

*Umm we've got a good relationship with Sophia (OT) I think she does recognise some of the complex things we have become involved in. She has got a good open mind and is an excellent worker.*

Sophia appeared to understand the roles and the difficulties that social workers faced. But what did he mean by having a 'good, open mind'? Exploring this further I noted that David described open-mindedness earlier in our conversation.

Ex.3.8

*Keeping an open mind is essential. A lot of people can develop a 'closed mind' and get cynical in this kind of work. I have me moments but I strive to keep an open mind and try not to be judgemental.*

For David, being open-minded appears to mean a particular way of thinking when approaching client care and social work in general. For instance, someone who is not being judgemental, or cynical, and not making disparaging remarks about clients or social workers. This was highlighted from a contrasting experience when David described a multi-professional case conference he attended.

Ex.3.9

*Doctors came out with funny phrases; really sarcastic about a particular client we were talking about, quite demeaning really. We tried to get to grips with a particular problem and he (the GP) was almost like a put down,*

*really rude as if we (social workers) are just pathetic. Well that is how you feel. Really sad because they (doctors) are so powerful the way they come across, it's quite awful really.*

### **Recognising and respecting the expertise**

Other relationships that David described as 'good' were with district nurses. However he felt these did vary according to personalities and individuals, and therefore should be positioned in the middle of the Salmon Line. Often, he felt that district nurses did not understand what social workers were able to do and were surprised when he was able to work fairly flexibly.

#### **Ex.3.10**

*I think particular with this case the nurses they kind of smile and been a bit surprised sometimes of what I appear to do. They know we do lots of things 'beyond the call of duty' but then again perhaps they do as well sometimes.*

In other cases where he was unable to respond so effectively, some district nurses reacted quite differently towards him.

#### **Ex.3.11**

*It's just no understanding, giving grief, or they get really angry, 'Why can't you do stuff?', 'Why can't you do this?', 'Why can't you put him in a home?' You know, I can understand they are going out and working really hard with lots of people who are really poorly and ill, and they see us not getting to grips with something. So I will put district nurses in the middle. (Fig.19)*

In contrast, David felt he worked better with the hospital staff as his efforts were acknowledged and respected.

Ex.3.12

*They respected everything else I was trying to do and they listened to me and I felt it was a positive exercise if anything else. It felt good that people were trying to work together. It was really good!*

From the above comments the way David viewed good relationships tended to be in terms of how others understood the role of a social care worker and their attitude towards social care problems. Moreover, he spoke as if it was unusual that health practitioners actually listened to him and valued his experience.

### **Back and forth communication**

Communication was another important aspect to good working relationships for David. It is notable that he placed the neighbour at the highest point on the dimensional line. Mr and Mrs Stamford did not have a telephone, and so their neighbour acted as a good 'go between', and would communicate quite frequently with David on behalf of Mrs Stamford. She would let him know when Mrs Stamford was distressed by any of the different home care arrangements, and she would pass on any information David wanted to relay to Mrs Stamford.

Furthermore, David considered this back and forth type of communication desirable when working with other practitioners. Interestingly, it was during the reflective task that

David remembered there were occasions when some GPs actually communicated very well with him, as he describes below.

Ex.3.13

*Had some good experiences in Church Lane practice and the GP in there recently. Very good with information – working together well passing the information backwards and forwards with the permission of the service user. So I hope I'm not being too judgemental on GPs ' cos I know that they are with us sometimes I understand that.*

Finally through the Salmon Line we discussed whether he was satisfied with his relationships with other community workers, and how he might improve his relationships and communications with the doctors. David suggested that working in the same environment as the GPs at the health clinic might promote a 'working together' where they could 'at least learn to understand each other'.

### **The responses to the interview experience**

Overall, the interview task appeared to create a situation where the participant was relaxed and comfortable enough to think aloud as well as to ask me questions. All of the participants set about their interview task with enthusiasm, and were willing to relay information about their work and their feelings, regardless of whether they were sitting on the floor or at a table. Often the participants needed reassurance that it was useful for them to talk about their work experiences; they would ask '*Is this useful to you?*' and '*Is this what you want?*' It seemed that for all the participants this was a rare experience for

them to just talk about themselves, their work and their feelings, so often they were the ones who were asking their clients the questions. Also, I felt this thoughtful, concerned type of response towards me was characteristic of the care professions, ensuring that they had met a person's needs.

The practitioners themselves found the layouts interesting and were amazed by the number of people involved in a case scenario. All of the practitioners I interviewed commented on the usefulness of the experience and how they could utilize the interview techniques as a reflective tool; for example, when involved in the complex care of an individual, or when reflecting upon their joint working relationships. There were times during the task that the process caused the practitioners to reflect upon certain situations, and to consider how they might improve their practice or relationships with other services. This was expressed in the length of pauses during the discussions and how they debated out loud over a particular course of action they had taken.

From a researcher's point of view the examples and descriptions did go beyond mere descriptions of a chosen scenario. The layouts facilitated graphic descriptions of the varying degrees of closeness in the professional relationships and helped me as an outsider to grasp the complexities of different roles of the practitioner in a joint working event. Also, the layouts served as a springboard for discussing other issues and other situations brought to our attention through doing the task.

Overall and more importantly, I felt the visual task did give me access to information that might not otherwise have been offered. Firstly, because the participants had become absorbed in the task: as a consequence, they sometimes rambled on in an uninhibited way. Secondly, I was able to prompt from the layout and the Salmon Line those people that the participants had not included in their initial explanations. For example, conversations tended to focus upon those whom they had intense relationships with. These would be practitioners placed at either end of the dimension scale, where relationships were very positive or where relationships were significantly poor. Therefore, I was able to prompt them concerning those practitioners who fell between the extremes, and say, 'What about this person or team?'

## **Conclusion**

In conclusion, I have found these reflective techniques (Hargreaves interpersonal networks technique and the Salmon Line), versatile and powerful tools for interviewing practitioners. Notably, this method provided rich descriptions of the individuals' relationships. From the visual display the practitioners were able to identify their goals and question their positions in the joint working scenario. The Salmon Line enabled them to identify areas that needed improvement, as well as consider strategies for changing their practice. In the next chapter I will present the findings from the other practitioners who participated in this study.

## Chapter 10.

### Study Three: Inter-professional constructs and networks

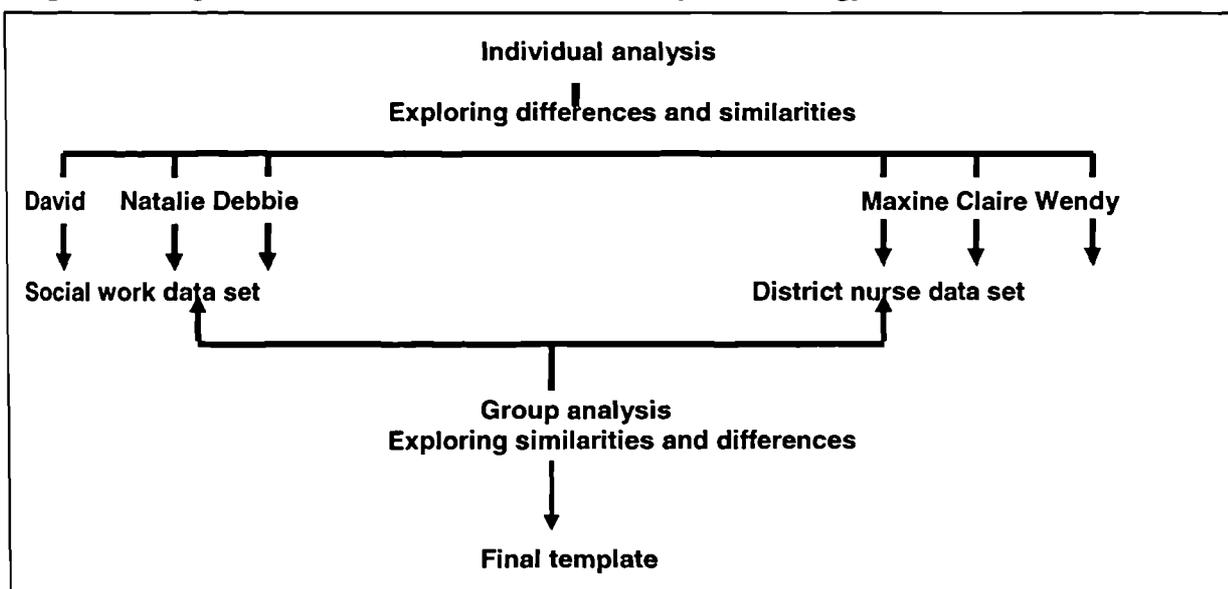
#### Part two: Findings and discussion

The previous chapter presented two cases of practitioners I had interviewed using a reflective, interactive interview style. This chapter will present the findings of all the other participants that took part in this study using the same method, followed by a discussion. Before I proceed I will briefly outline the analytical strategy and technique used for this part of the study.

#### Analysis

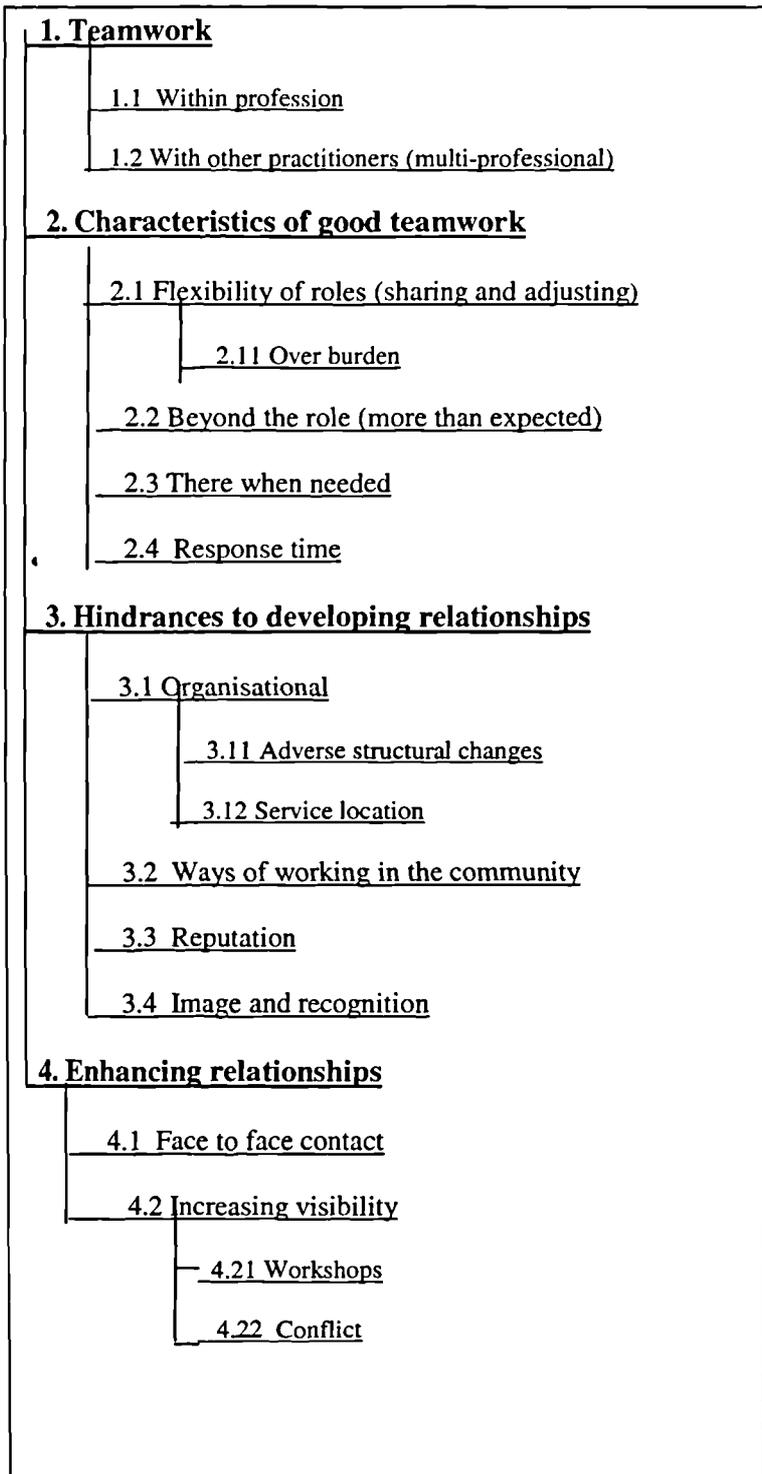
To analyse the data I utilised a similar analytical strategy and technique to that described in the student study (Chapter 5 p. 104), that is, I worked on each data set separately before merging the coding templates (see fig.20 below). All the interviews were taped and transcribed verbatim, and I used the template analysis technique as described in the previous studies (Chapter 5 and Chapter 7).

Fig. 20. Interpersonal networks data set and analytical strategy



From the template analysis the themes that emerged from the data are summarised in the box below.

**Fig.21. Inter-professional relationships template**



## Findings

### Teamwork

It became apparent from the scripts and the inter-professional layouts that teamwork was very important to all of the participants, both when working within their respective services and with other practitioners. On close examination there were subtle differences between district nurses and social care workers in how the practitioners positioned themselves within their practice team and how they related to other teams. For example, whilst presenting the inter-professional layouts the district nurses referred to themselves as the '*district nurse team*' on the arrow shaped cards, or '*we*' when describing care. In contrast the social care practitioners often referred to themselves as '*I*,' and wrote their individual job titles upon the arrow-shaped cards (see Appendix).

This is not to say that social care practitioners worked independent of other practice members, on the contrary, they worked with others, and supported other social care practitioners within their designated team. However, the way social care staff worked often meant that they were responsible for a client on an individual basis, and would remain the principle contact for that client throughout their care, whereas district nurses shared their patient care across the district nurse team. The nurses' sharing of patient care was a practical necessity, as they would rely upon each other for support and continuation of care for patients when staff were absent; as for example, in the case of Maxine (district nurse) who worked part-time. Furthermore, Wendy (district nurse) outlined how they shared patients amongst the district nurse team to prevent patients from becoming '*too reliant upon that one person*'. I took this to mean that the patient would become

physically and emotionally dependent upon one nurse to supply all their 'nursing' (physical and emotional) needs, which would be tiring and time consuming for one nurse. However, closer examination of the scripts showed that district nurses also shared patients according to the different skills within the district nurse team. For example, one district nurse might have been supervising care of a client with a wound, but might have called upon another district nurse (with a particular expertise in this area) to give advice and treatment.

Moving on, the district nurse's use of team illustrates a sense of closeness between the nurses that was not so apparent among the social care teams. From my previous findings, this closeness of district nurse team members may stem from the way the practitioners were socialised. The earlier study (chapter 5) suggested that student district nurses appeared to have a stronger sense of group identity than the student social workers. This sense of identity and belonging was strengthened by their professional values, the professional organisations they belonged to, and their uniform (Ex.1.19, p.123). So how does this notion of teamwork and closeness extend to other practitioners?

### **The multidisciplinary team**

With regard to working with other professional disciplines the district nurses were more inclined to explicitly use the term 'team' than the social care workers.

Notably, Maxine mentioned 'team' a number of times in quick succession to emphasise her feelings on the topic (see Chapter 9, Ex.3.1, p.255). Again, the word 'team' was associated with 'closeness' and 'working together' as a unified group.

Likewise, Claire emphasised teamwork, as a way of contrasting present and past working practices.

Ex.3.14

Claire: *I could remember the opposition (to doing venepuncture) 'We (district nurses) don't do that, it's a doctors job'. 'You don't do that, you don't get paid for it!' They (those district nurses) worked separately, but we work as a team.*

(District nurse)

So why was there this particular emphasis on teamwork amongst the district nurses? Claire reminds us that historically the different professions worked separately, with very distinct roles, and how in the past she was not encouraged to take on work across the boundaries. Interestingly, Maxine stated that the different professions were now *'trying to be a team'*, which suggests that such team work with other practitioners was something that did not come 'easily', but involved conscious consideration and effort to change ways of working and thinking.

For the social care practitioners, 'working together' with other disciplines was not so strongly emphasised as the district nurses. Relationships tended to be described as 'working alongside' rather than 'together'. For example Debbie (homecare manager) described her relationships with district nurses more in terms of confidence and knowing that there was someone there to contact if needed.

Ex.3.15

Debbie: *sometimes the district nurses get a call from 'night call' (GP on call service) and have been asked to go and see to somebody. They (district nurses)*

*may have not been in the area (that night) so they ring through to my out of hours staff , 'Can you go and change this person?', and that works quite well and it works the other way round, if staff get to somebody and they (home care staff) are very concerned about somebody, sometimes they will ring the district nurses and leave it to the district nurses.*

(Homecare manager)

Debbie seems to suggest that some of the relationships between district nurses and social care workers were relatively close. They had become so accustomed to each other's activities, and so fixed upon achieving their goals, that their relationship could be taken for granted. They were not necessarily close in terms of knowing each other personally but Debbie appeared satisfied that the support was there when they needed it.

### **Characteristics of good teamwork**

From the Salmon Line it became obvious there were some services that the participants found difficult to relate to as part of the team. Often they were the GPs and the acute service staff (See Appendix, p.378). This led me to examine the ways practitioners described 'good' team working relationships.

#### **i. Flexibility**

A predominant theme throughout the analysis was the notion of flexibility. For example, this was used to illustrate the adaptability of district nursing and the breadth of their skills.

Ex.3.16

*Wendy: I think district nursing is the most flexible profession out there because anybody who wants to know anything 'we ask the district nurse'.*

(District nurse)

Flexibility may also mean a willingness to negotiate roles and share tasks, rather than adhering rigidly to traditional practices, and performing tasks that were assigned to a particular role (Ex.3.3, p.255). In my conversation with Claire, she described a pragmatic approach to her work, where there were fewer specific professional boundaries and where a particular group no longer owned tasks.

Ex.3.17

*Claire: Cross-work, a lot of cross-practice. There are no defined roles, (such as 'this is Trust work', 'this is community work', and 'this is GP work'. It's team work now! (Later she adds) If they (the doctors) were going to a house and they wanted some bloods taking and they were going anyway, I wouldn't mind saying 'while you're there would you take these bloods for me?' Or the classic is the flu vaccine, we do the house-bound and residential homes and the practice staff will do the walking wounded, so to speak, it's a joint thing!*

(District nurse)

Claire takes the view that professions have fewer boundaries than before, and are now no longer bound to particular tasks.

On the one hand, flexibility appeared to be a good thing in order to share tasks and to work closely as a team. On the other hand, flexibility without defined roles left some

practitioners feeling that they were overburdened in terms of responsibility and workload. Maxine below implies that if boundaries are not drawn between professionals, then district nurses will automatically take the responsibility for meeting client needs.

Ex.3.18

*Maxine: It takes me so long - because I'm looking at everything trying to pick up (pauses). (I'm thinking) is there any of the services that they are not getting but should be getting. (Umm) I think the problem with district nursing; there is no defined line. We (district nurses) tend to, you know, take it as our responsibility to make sure that (action) happens. I think we put a lot of pressure on ourselves, whereas Social Services will say I can't go until tomorrow, whereas we would go today.*

(District nurse)

Below, Wendy cites one instance of how others might have taken advantage of the district nurses' flexibility.

Ex.3.19

*Wendy: Since the nursing review, we (district nurses) have got criteria for admissions, as a lot of people (other practitioners) tried to put stuff (other work) onto us.*

(District nurse)

Further into our conversation, Wendy explained that the burden might largely be self-imposed, stemming from how district nurses interpret their responsibilities and roles. Also, she suggests that district nurses tend to overburden themselves because of 'the type' of people they are, as well as what they like to do.

Ex.3.20

Wendy: *We're soft I think, most nurses are very soft and take the responsibility and feel the responsibility for people who are poorly, but also a lot of nurses like caring for patients with palliative care needs, they get a lot of job satisfaction.*

(District nurse)

Wendy raises some interesting questions about the source of the nurses' sense of burden and responsibility. First she implies that it is the 'softness' that creates *the* burden. What does she mean? Is she criticising the way nurses work, and claiming that nurses are to blame for the workload they put on themselves, or is she wanting sympathy because they feel obliged to take on these responsibilities? Second, why does she associate 'softness' with palliative care? On close examination of our discussion it became apparent that there was a tension between some of her 'sedimented' ideas concerning the nurses' role and the desire to take on the 'new' managerial roles of the nurse.

Notably, Wendy associates 'softness' as something that is particularly characteristic of nurses and is expressed in a type of caring, which involves 'hands on' physical and emotional support. In support of my earlier findings, she observes that there are many district nurses who enjoy this sense of personal involvement with a client (Chapter 6), and who can continue with this involvement through specialising in palliative care. Later, Wendy informed that she preferred the challenges of managing and coordinating cases. Interestingly, I sensed she felt uncomfortable and unsure about disclosing this information to me. I would suggest that this discomfort may be attributed to the way that she anticipated my concepts of the nurse's role. That is, I would have a traditional view

of what a nurse should do, and that I would therefore, disapprove of her enthusiasm for more managerial approach to nursing. This is further illustrated by her next comment,

Ex 3.21

*Wendy: You should be a nurse who still enjoys doing a bed bath and what not.*

(District nurse)

Wendy went onto to justify why she felt her form of caring was still nursing.

For some district nurses, then, the burden of responsibility may come as a result of the tensions between the expectations of their employers, the public's perceptions of the caring role, and the way the nurses themselves construe the role of the nurse.

Overall, the district nurses seemed to suggest that the burden of responsibility and care towards the client was something unique to nurses. Furthermore, some district nurses felt that Social Services did not have the same burden of responsibility and care because Social Services did not have the same sense of urgency (Ex. 3.18, p.276) attached to their role (I have elaborated this further on p.283-84). However, David (senior practitioner) points out that social care workers overburdened themselves in a different way.

Ex. 3.22

*David: They (Social Services) would like us to close cases and take new ones on and we do get clogged up with people's needs. There are people who don't have somebody who they can turn to. So I hold onto about, probably got between six and ten cases, which I have had for a year or two years. Unusual, complicated stuff, which I wouldn't expect somebody else to pick up and it wouldn't be fair to*

*the service user so I hang on to them.*

(Senior practitioner)

Here David explained how some practitioners have kept clients on long-term, when the department would have liked them to address particular needs and 'close cases'. Nevertheless, David clearly felt a personal responsibility in providing long-term, continuing care for certain clients with complex needs. This was something that he was willing to do (he liked to do), even though, it went against the expectations of the organisation that he worked for. I might add that David's description of the way he worked resembles the casework style of social work, which was standard practice before the introduction of the purchaser-provider split in 1994 (See chapter 3, p.50-1).

Ex.3.23

*David: In some ways we overburden ourselves because we like to make ourselves available to stop people (from being) caught in a bureaucracy.*

(Senior practitioner)

Similar to Wendy, David's comment here seems to say something about the 'nature' of the care professions and the aspects of their work that they take pleasure in. Furthermore, David's comments highlight how he is reluctant to leave behind some aspects of past ways of working because they support his notion of what it is to be a 'social worker'.

Overall the above examples suggest how practitioners may 'overburden' themselves in responding to the needs of clients or patients, by the way they interpret their roles, and by the expectations that they felt others placed upon them. In order to meet 'needs', and to

fulfil their own and others' expectations, some practitioners were willing to go beyond their role. This leads us to the next theme.

## ii. Beyond the role

So far I have identified how some practitioners construe the need for flexibility in order to work effectively as a team. In addition, some practitioners described a willingness to go beyond their role in order to '*make a difference*' for the client (for example, see Chapter 9, Ex.3.3. p.255) For example, David (senior practitioner) commented that he was prepared to extend his role to go what he considered '*beyond the call of duty*', in order to respond to a client's needs and to gain a client's trust. Here David describes some of the things he is prepared to do for his elderly clients.

Ex.3.24

*David: For example fitting toilet seats and changing light bulbs, switching electricity back on when it has gone off. Flicking a switch, or just simple repairs to secure a back door, and anything I can do just to show willing, to show a kind face. We go beyond the pale; I have been wading into people's houses shifting, shovelling rubbish away, hundreds of bags of rubbish and bottles and all kinds of things, anything from changing a light bulb to doing the assessment.*

(Senior practitioner)

Going beyond the role or the 'call of duty', has meant more than just sharing job roles. Often it has meant personal sacrifice in performing tasks that no one else would do, or giving up personal time in order to respond to a client (see 'Response time' later in the findings). These acts of personal sacrifice showed a sense of commitment to the client, which was particularly admired and recognised by the district nurses (Chapter 9, p.255).

Perhaps David's long description illustrated how he felt he needed to show me the value of social care workers and to dispel the myth –'that they are not a waste of time' (See Chapter 5, p.116).

In contrast there were practitioners who were perceived as unwilling to go and get involved) beyond their job role or specialty: these practitioners were seen as specialists who dealt with particular parts of the person rather than the 'whole'. Often these practitioners were placed towards the 'poor' end of the Salmon Line (see Appendix). For example David described the GP as someone who kept his distance and did not want to get involved with social issues. This is exemplified further by the district nurses' illustrations below.

Ex.3.25

*Maxine: They (Diabetic nurses) deal with their specialty and they do not look at the whole thing. They sort out diabetes but if they (patients) have got MS (as well). They (diabetic team) are not looking at the whole picture.*

(District nurse)

Ex.3.26

*Claire: They (medical staff) are very acute focused, they just see are they (the patients) worse or getting better? The ward nurses are pretty much the same, they are very 'treadmilly', focused on acute care and don't relate to outside. OT, physio and hospital social workers work completely different. These people really know what its about, transferring patients out, about care in the community about what works.*

(District nurse)

In the above comments both Claire and Maxine described situations where in their opinion, there were practitioners who only viewed the person in terms of the condition they presented with. Compared to the holistic approach of community nursing, this 'specialist' nursing approach was construed as a partial knowledge, which did not necessarily meet the client's needs. Also, on closer examination they appeared to be saying something about the cultural differences in approaches to care, and the tensions that existed between hospital and community teams (see also Chapter 8 p.200). Claire in particular points out that the style of acute nursing care is mundane and almost task-orientated – a reminder of 'past days' (Ex.3.14. p.273), where past attitudes did not generate the same sense of working together. There was a sense of relief in her tone as if to say the community team was indeed progressive; in the way they shared the same holistic views concerning the person in the community, and the involvement of other services.

### **3. There when needed**

In contrast, there were other 'specialist' relationships that were highly valued in terms of the support and the expertise that they provided. For example, Debbie would call upon the expertise of a specialist OT,

Ex.3.27

*Debbie: If we have a major problem Tina will come out and help us with it on a one to one basis. The other OTs that are based with Tina will work and provide equipment for trainers, or will show us (home care) how the equipment should be used. But Tina will work with individuals, but they (other OT's) don't normally do*

*trouble shooting, but Tina is the one we (home care) sort of pull in and I haven't needed her in this instance because we know what we are doing with this guy (service user in the scenario) but where we get some sort of resistance (by the clients), so maybe putting in equipment which is necessary, Tina will come out and explain exactly what we can and what we can't do.*

(Home care manager)

Here Debbie drew upon the services of Tina, as someone who was there to provide that personal support, and someone who applied their expertise to the needs in the community. This was illustrated earlier in the case study of Maxine where she enthusiastically identified the Mattress Coordinator as someone with expert advice and who could sort out her problems (Ex.3.4 p.256) in a specific field.

Also, knowing a person was there when needed generated trust, and a confidence between the practitioners that a particular task or work would be completed. Natalie (senior practitioner) highlights a contrasting experience.

Ex.3.28

*Natalie: I put her a bit there (placing card towards the middle of the dimensional line) because this is a lady (OT) whom I don't trust a 100% to do the job, (she) has to be chased up constantly, that's why I put her there- previous experience means I feel that we will have to chase that up.*

(Senior practitioner)

### **Response time.**

For some practitioners, 'being there when needed' involved responding within a time limit. For example, the previous student study (chapter 5) identified contrasting

interpretations of response time between district nurses and social care workers. Often the district nurses would try to respond within hours of a referral (Chapter 6 p.135.) It was difficult to ascertain from the district nurse scripts whether the drive to respond quickly was a professional expectation or a personal obligation.

However, the way practitioners construed response time appeared to illustrate the fundamental differences between district nurses and social care workers, in terms of their approach to care and their personal expectations. For the district nurses, not responding swiftly to a patient would be construed as uncaring, not fulfilling their responsibilities and their role.

For the social care workers there was a different approach required to dealing with social problems. At times an immediate response was not deemed necessary; as David explains below.

Ex.3.29

David: *We (social workers) don't always respond so quickly as nurses would like. They are going out with medical problems which need dealing with, its there, its a problem we can see, it needs to be treated. We (social care) go out there we identify a problem but they (my clients) may choose not to have it dealt with because it is something that they want to live with.*

(Senior practitioner)

Also, Natalie highlighted how the different services had different expectations.

Ex.3.30

*Natalie: Health has expectations, if a person is living in a certain state of the house that isn't very clean. They (the clients) are not very clean, but actually, they don't want any help. They (health practitioners) find that more difficult to accept that the Social Services are saying 'its not life threatening, they (the client) can make their own decision, that's up to them, give them the information and they can make their own choices'.*

(Senior practitioner)

The social care workers argued that many social situations were long-term, not necessarily life threatening and involved a sense of choice on behalf of the client. In contrast, there were medical problems and conditions that required immediate treatment, and the element of choice for the client was not so apparent.

However, there were situations in which social care workers did respond within the same day of referral.

Ex.3.31

*Wendy: I was well impressed in how quick they (Social Services) acted and they (Social Services) appeared to understand the situation as clear as glass. Then the community social (care) worker went in that morning and did an assessment and got services started that evening. They (Social Services) were excellent Angie, I must admit (laughs).*

(District nurse)

Wendy was surprised by the swift action of the social care assessor, as if this was something unusual. Her laugh and tone of her voice indicated to me that she had recognised her comment had contradicted her previous views concerning the response time of social care workers. I might add, the style of the interview gave the practitioner time to reflect, and therefore, it was likely that this awareness emerged because of the technique.

### **Hindrances to inter-professional relationships**

Overall the practitioners described relationships between district nurses and social care services in the community as good. Through using the layouts and the Salmon Line the practitioners identified potential barriers to forming good working relations, and identified possible solutions towards how they might improve these relationships. First I shall examine the potential barriers.

#### **i. Organisational changes and developments**

The social care workers tended to highlight how organisational changes had altered their job roles as well as their relationships with other practitioners. In particular Debbie pointed out how homecare managers no longer had direct contact and communication with other health practitioners.

Ex.3.32

*Debbie: We used to go to doctors' meetings when we were doing the assessing and the providing. Home care used to do the assessing, then it split, so we are just*

*the providers now. The assessors go to the doctors' meetings and meet the doctors and the district nurses, but we (home care) are not invited.*

(Home care manager)

The changes within the organisation meant she was no longer included in meetings, and much of her communication with the health practitioners was now through the social care assessors.

Ex.3.33

*Debbie: If I need to talk to any of the doctors of that particular case I usually go to the lead assessor who goes regularly to the meetings and then rings back information. What happens is that unfortunately at the moment, Angie, what we're finding is because we don't get that much involved with the nurses, when the service user is on the hospital visit, we don't always get invited to the home visit.*

(Home care manager)

Debbie made no overt indication as to whether or not she preferred to return to the previous ways of working, but appeared frustrated by her exclusion from meetings, and by the lack of direct communication with health practitioners. In particular, Debbie felt it was essential for home care to be present at case conferences, meetings and home visits in order to discuss and negotiate the care that they would be able to provide for the client. Now that she was no longer involved and visible to other health practitioners, it was possible that home care managers' contributions might go unrecognised at coordinating level.

The exclusion of homecare from meetings was not necessarily intentional on behalf of the district nurses. From the district nurses' viewpoint, the continuing organisational developments and the structural changes of the social services appeared confusing, and at times overwhelming. Wendy described the complexity of coordinating the care of a patient who was ill at the home.

Ex.3. 34

*Wendy: But then there seems to be so many people to tell and you're probably not too sure who's who (referring to home care and housing departments on the layout). I think part of the problem might be not having any contact numbers for all these people, and not realising the structure of the system, because I know you have got the community social worker who does the assessment and she passes onto home care manager, we normally liase with either of these two. Then there seems to be another layer of management in and amongst (referring to Social Services).*

(District nurse)

The analysis also revealed that the 'nature' of working in the community was in itself a hindrance to developing close relationships. Working as a community practitioner often meant being out of the office, and therefore it was difficult to communicate with people who worked in a similar way. Frequently, communication was by phone.

Ex.3.35

*Wendy: I think with both (district nurses and social care workers) of us working in the field you phone them up and they are never there. So you leave messages and they will return your call when you're out sometimes. It's quite frustrating trying*

*to catch people and they must think the same about us. Many a message is left on an answer machine.*

(District nurse)

In addition, the turn over and movement of staff within a service made it harder for practitioners to establish and maintain close relationships.

Ex.3.36

*Debbie: What tends to happen with the district nursing service is that they change people around, they move them around, and after so many years of working within the area they move them elsewhere usually. So you build up a kind of a good working relationships with a district nurse, and you build up trust and confidence don't you, and then somebody new comes in.*

(Home care manager)

## **ii. Reputation and misunderstandings**

I have shown by the above examples how the way services are structured and developed sometimes hinder close working relationships between services, and between individual practitioners. Another potential hindrance is the type of reputation a service develops. For example, Claire recounts how district nurses gained a particular reputation with hospital staff.

Ex.3.37

*Claire: It's just a misunderstanding, lot of the ward staff used to be petrified of district nurses because of the old style district nurse. The older (district) nurses that have been there a long time would get a junior staff nurse and wipe the floor*

*with them. It still happens from time to time but we try and change.*

(District nurse)

Apparently, the district nurses had gained a reputation of only contacting the ward if there was a problem or a complaint about a 'bad discharge'. It was not surprising, therefore, that when Wendy contacted the hospital staff concerning a patient's discharge they appeared defensive and unhelpful.

Ex.3.38

*Wendy: I got in touch with the ward staff and they were on the defence and they thought, well, I was criticising but I was trying not to be critical, just sort of say, 'What is going on here? This is the state the lady is in', and they (ward staff) were very defensive.*

(District nurse)

Unfortunately, Wendy was unable to resolve her communication difficulties with the ward staff at the time of contact, and was left feeling frustrated and unsupported.

This was in contrast to some of the social care workers' experiences. David described how the hospital staff had respected and listened to his advice and views on a client situation (See Ex. 3.12. p.265).

### **iii. Image and recognition**

From the analysis it transpired that some misunderstandings and conflicts over roles and capabilities were associated with a profession's past image. Claire points out below how she feels that the public considers district nursing as an 'unskilled job', and how she thinks the media has contributed to this view.

Ex: 3:39

*Claire: Patients say to you 'Have you ever tried to get a proper job in the hospital', and 'What kind of nurse would you be?' Gladys Emmanuel did us no favours and what was that other one (TV. programme) 'Where the heart is', where they (district nurses) go round in pairs and have cups of tea everywhere? – Does us (district nurses) no favours.*

(District nurse)

Also, Wendy stated how the public were not aware of the district nurse's knowledge; she felt the nurse was still perceived as a handmaiden. Later on in our conversation, Wendy described how nurses have battled to rid themselves of the 'handmaiden' image.

Ex.3.40

*Wendy: The nurses have been working for many years to get away from that image. But now things have developed in the physiotherapist, the OTs, the orthodontics and the podiatrists, and all these other professions have come on board. Well they have always been there but they have now got a higher profile. I feel and I think the competition is with them now and they (therapists) think that district nurses are handmaidens really. I think the therapists think that they are the key workers and the district nurses are the subservient ones, and I think that's wrong' cos we should all be working as equals.*

(District nurse)

Interestingly, Wendy feels she needs to compete with, rather than collaborate with certain practitioners, in order to be recognised and valued as a highly qualified and skilled practitioner.

In contrast, the social care workers recounted how they had inadvertently acquired a reputation with the public and other practitioners concerning their authority that was misleading (this was illustrated in the earlier student study chapter 6, p.123-4). David and Natalie explain below.

Ex.3.41

David: *I think a lot of people are under the illusion that we have more power than we actually have. Not just the district nurses but I think it's the public in general. If we have a vulnerable adult for example, in any situation (of neglect or abuse) I think they expect us to go out, and take him away and take him into care.*

(Senior practitioner)

Ex.3.42

Natalie: *Obviously they (the public) know the service we provide, they think we have more power than we have, in that if somebody is in a situation that they don't feel very happy about, that we can whip them in and out into a better situation without having their consent.*

(Senior practitioner)

Again, the above examples illustrate the different expectations placed upon health and social care workers concerning interventions and the exercising of authority. From David's earlier example (Ex.3.10. p.264), it appears that the social care workers were as keen to rid themselves of the public's conception of their role as the district nurses, and would go beyond their role to do so.

## **Finding solutions**

Through the Salmon Line I discussed with some of the practitioners ways that they might improve their relationships with other services, particularly with those relationships they had described as problematic.

### **i. Face to face contact**

The preferred form of communication for all of the practitioners was face-to-face contact. Often the district nurses and social care practitioners were isolated from each other each other, and much of their contact was by telephone without having met face to face. Below, Wendy (district nurse) describes her encounter with the social care worker.

Ex.3.43

*Wendy: The lady (social care assessor) arrived as I was leaving, so she introduced herself and stopped. 'Its lovely to put a face to a name' (she said), cos I referred her, so she knew she had me name down, but she didn't know who I was from Adam, and I didn't know who she looked like, I didn't even know her name to be honest beforehand.*

(District nurse)

Natalie explains how face-to-face contact is important and facilitates communication and commitment between practitioners.

Ex.3.44

*Natalie: Because people put a name to a face and I think that makes them communicate more when they actually know who it is and they have met that person, and I think sitting around with the service user makes people more*

*committed, and if things are put down in writing and there is an action plan that makes it more focused, whereas you can lose things along the way if you don't have face to face. It's not always appropriate in every case but I think there should be more face-to-face meetings than constant telephone contact.*

(Senior practitioner)

The difficulty was could community practitioners create opportunities to ensure some face-to-face contact with one another?

## **ii. Increasing visibility: other opportunities**

Some of the practitioners had opportunities through aspects of their role.

Ex.3.45

*Claire: It has been an awareness thing I think really that's improved the joint working. It's (the Intermediate care worker role) given me a chance because I sit in on the (hospital) meetings they (consultant and medical team) have got use to us (district nurses) going on because we have built up relationships here. They have got used to me now, it's taking a lot of awareness really, raising, getting them use to me – so that's been a very gradual process but the ward staff. I have been on every ward as much as I can for the last 3 months. They seem to know a bit more about what it's about and often they will ring me direct.*

(District nurse)

Claire discussed how it was through spending time with hospital staff that she was able to build relationships, and trust between hospital and community services. However, it was

Claire's role as intermediate care manager that created the opportunity for her to meet hospital staff and to raise awareness of the district nurses' capabilities.

In practices where staff groups did not have the same opportunities as Claire, Wendy argued that district nurses needed to initiate the action and relationships, rather than wait until they were invited.

Ex.3.46

*Wendy: I suppose it is by good working relationships when you go to meetings or like instigating and forcing ourselves. For example, inviting ourselves to case conference in hospital by going onto the ward, and I suppose we are all here to help, which we are, Angie.*

(District nurse)

Likewise, David (senior practitioner: social care) endeavoured to raise people's awareness of his skills and abilities at case conferences and meetings.

Ex.3.47

*David: I'm trying to support the district nurses in making suggestions and ideas, so when it comes to the ward rounds and at the case conferences they often turn to me, and (say) 'What do you think?'*

(Senior practitioner and social care assessor)

Through his contact with hospital and community staff, they had come to respect his knowledge and skills.

Ex.3.48

David: *I work with the Mistlethwaite (district nurse) team, they often turn to me if they have got a new client anyway and just check out ideas or pass concerns backwards and forwards.*

(Senior practitioner)

Consequently teamwork with these service practitioners was a satisfying and rewarding experience.

### ***Workshops***

Some of the participants pointed out that there were organisational structures put in place to discuss differences and developments between the acute and community services. For example, Wendy thought that she would be able to bring her difficulties with the Acute Trust services, to the hospital community interface group meetings. Also, Claire mentioned that there were professional forums which provided a '*non threatening environment*' to help people to adjust to changes and discuss ways of improving practice. Interestingly, there were no comments about how they might improve relations between district nurses and social care workers.

The social care participants did not discuss the use of inter-professional forums within the NHS Trust. However, Natalie felt there was a need for undergraduate joint training between health and Social Services. This would create an ideal opportunity to meet with other practitioners and learn to understand each other's roles.

Ex.3.49

Natalie: *We should have more joint training on these things, these kinds of issues you know, so they (health) understand more. But then its up to us to communicate that as well, and perhaps have joint meetings with them as well.*

(Senior Practitioner)

### ***Conflict***

Finally, it was apparent that conflict created an opportunity to discuss and address the relational problems between services. It was the conflict that Wendy had experienced with the hospital staff that prompted her to consider ways she might address her communication difficulties and differences. This is further illustrated by Natalie's experience. As part of her chosen scenario, Natalie discussed a misunderstanding between social care staff and the district nurses over the care of a client. Following a meeting that she had with the district nurse manager, district nurses and a carer, differences were able to be resolved, and consequently their relationships improved.

Ex. 3.50

Natalie: *If it was me that was the central focal point (pointing to the layout) I think the district nurse team would be pretty close (position of cards). They (the district nurses) were quite upset about it (the complaint) at first, but it seems to be a really good relationship with them now.*

(Senior Practitioner)

Throughout the conflict and disagreement over care, Natalie was impressed with how the district nurses managed the situation: they had come to understand the needs of the client but also the input of the social care workers.

## **Discussion**

This study has focused on how individual practitioners negotiate and interact with others in a multi-professional event. It was evident through the visual layouts and descriptions, that cooperation between practitioners played an important role for the smooth coordination of services. Often these joint working situations were finely balanced, involving numerous services intricately woven together to form a supportive network for the client. Having anticipated and identified the needs of the client, the coordinating practitioner would call upon the services of the appropriate professionals. In many cases, the relationships with certain members of the team were taken for granted. It was through the reflective technique that I was able to explore these 'taken for granted' relationships between the practitioners, and uncover important themes that they felt contributed towards effective and meaningful team working relationships. These themes I have described as; being there, commitment (personal sacrifice), flexibility, and understanding and anticipating roles. To enhance our understanding of the complexity of and constraints upon professional identities and relationships I will draw upon the concepts of sociality, experience, and sedimentation.

### **Being there**

'Being there' appeared an important construct for the practitioners in terms of how they viewed others as part of their team. 'Being there' meant an unspoken level of involvement, which the practitioners had come to anticipate, each practitioner relying upon and trusting each other to provide the appropriate support and skill. This sense of knowing that there was a service 'on hand' to provide a particular part of a client's care,

led to the smooth coordination of services; for instance, Debbie took for granted that the district nurses were there to be called upon if the need arose. Often this sense of knowing that 'the job will be done' had developed through many experiences of working together in a complementary way. In contrast to 'being there', practitioners described times where there was a perceived breakdown in the process; the coordinating practitioner then had to adjust his or her roles and actions, or pursue other practitioners, to ensure the agreed work was done.

### **Personal sacrifice**

'Being there' sometimes meant personal sacrifice on behalf of a practitioner in order to meet the need of a particular client. From the analysis it was clear that fulfilling the needs of the client was what gave meaning and purpose to being a care professional. Moreover, it appeared that to be 'caring' necessitated acts of personal sacrifice; either in terms of time or in the type of tasks practitioners were willing to perform. For example, district nurses described the times when they would forfeit their lunch periods to respond swiftly to a referral, and social care workers described how they would perform tasks that no one else would do. In spite of the extra workload and responsibility these selfless acts seemed to create, the practitioners claimed that this was something they wanted to do in order to alleviate the social or physical discomfort in a client. However, what was presented as a personal desire to 'be caring' might also have been a response to deeply embedded cultural and historical expectations.

The literature informs us that one of the ways professionals demonstrated their status was through altruistic acts towards the public (Friedson, 2001). Nursing in particular is historically regarded as a subservient, selfless vocation (Abel-Smith, 1979). Therefore, it may be argued that the public have come to anticipate a caring profession to act in ways that are 'beyond the call of duty'; certainly the practitioners interviewed here expected this level of commitment from themselves.

Interestingly, it emerged from the findings that neither the nurses nor the public expected selfless acts from social care workers. According to the social care practitioners, both nurses and the public were surprised at the tasks that social care workers were willing to do. It is possible that these selfless acts are largely unseen by others. Earlier writers argue that a relatively small number of people have had personal encounters with social care (Horner, 2003). Consequently, it may be argued that most people's perceptions of the profession mainly depend upon the media or 'hearsay'. My earlier comments concerning the relationship between recognition and visibility (chapter 5, p.159) may play an important role. I shall return to this issue of personal encounter and visibility later in the discussion.

### **Flexibility and Sedimentation**

Flexibility has been a reoccurring theme throughout this thesis, and is acknowledged as a fundamental aspect of joint working within the community. Flexibility was often defined by district nurses as the sharing of roles (Claire), and in the case of social care workers an 'open' attitude towards ways of working and perceiving the client (p.263).

The majority of the practitioners were happy to modify or reconstruct their roles, largely because they felt this was enriching (elaborating) their practice, as well as meeting the client's needs. However, as my earlier studies (chapters 5 and 6) demonstrate, there were occasions where practitioners felt they were not always free to re-construct their roles and practice. A few of the practitioners tended to attribute this lack of freedom to the inherent qualities of the profession. For example Wendy (district nurse) stated that nurses were 'soft', and that the nurses' actions reflected the type of people they were (Ex.3.20. p. 277). Other practitioners have argued that organisational changes and resources have inhibited role re-construction or development.

Throughout I have argued that people are not determined by either internal or external factors, but people act, change, and develop in relation to others. However, I acknowledge that our interactions may be tied to our past relationships and social practices, in a 'sedimented' way. To reiterate, sedimentation is where people have retained ideas and patterns of behaviour through their interactions with others. These behaviours may become fixed through cultural values, and expectations that are placed upon them by others, for example, as a result of the socialisation process (Merleau- Ponty 1962, Butt, 1998). From my findings, practitioners recounted times when the sharing or extending of roles was verbally opposed by others within the same profession- (Ex. 3.14.p. 273), as it was 'not their job!'. These responses from others, and the way the service was organised may have contributed to 'sedimented' patterns of acting. As Butt (1998) argues people may perpetuate their patterns of behaviour because their

*'sedimented interactions and anticipations draw them back'* (p.278) into historic ways of behaving and thinking.

I would add, as many of our actions are pre-reflective, practitioners may be unaware of the influence of these 'sedimented interactions' unless forced to deliberate upon them. For example, nurses may be automatically (unconsciously) drawn into continuing 'hands on nursing tasks' because it is the way they have come to expect and anticipate a nurse's role. Likewise, David explained how many social care assessors continued their old style of casework practice with some clients. These 'sedimented' aspects of working are then strengthened by the responses of other practitioners, the public and the clients. Equally, other practitioners may revert to 'old practices' as they are familiar, and in the words of Butt (1998) it has become a *'comfortable house in which they have learnt to dwell'* (p.276). Kelly (1977) sheds further light,

*'Knowing a little something for sure, something gleaned out of one's experience, is often a way of knowing one's self for sure, and thus holding on to an identity, even an unhappy identity.'* (p.7)

Therefore, from our understanding of the relationships between people it is understandable that some practitioners may find it difficult to disengage from familiar roles and expectations: even if practitioners are aware of, and unhappy about perpetuating old ways of working, they are unlikely to discontinue these practices unless they know how to do something else (Butt, 1998).

### **Understanding and anticipating roles.**

For the participants in this study, good joint working meant collaborating with those practitioners who held similar views regarding care in the community. Duck (1979) asserts the importance of similar constructions within relationships if mutual understanding is to take place,

*'The more similar one's constructs to another the easier it will be to grasp the other's psychological processes.'* (p.392)

It can be assumed that through sharing similar constructs there is likely to be a mutual understanding and anticipation of each other's role within a joint working event. At first glance it could be said that the practitioners appeared to have a good understanding of what was expected from each service. For example, the practitioners understood the different response times to a referral, and acted accordingly. However, the same practitioners stated that others did not understand their role or their approach to work. So what did they mean by this?

Understanding one another's roles is often interpreted in the literature as a cognitive (*prior*) evaluation of the way another person works; this implies that practitioners need, first to think consciously about the way they work, and to understand what others do before they will be able to work effectively with others. From my findings I argue that this view does not capture the practitioners' meaning of understanding each other's role, nor the way that they work. However, if we take the view that that our thinking is also embodied and pre-reflective we can begin to see a level of understanding that is like an unspoken social dance; a sense of knowing between people that is formed in action (Butt, 1998). It is this sense of knowing and anticipating each other's actions within a social

event (which Kelly calls 'sociality') that the practitioners appeared to struggle with, and wanted to develop. If we see that many of our actions are embodied, then we can begin to appreciate how practitioners may reconstrue their identity and develop different ways of working, through personal encounter and interactive experience.

### **Personal encounter and experience**

As I have highlighted in earlier chapters, not all interactions between practitioners are in person. Some practitioners have built up a good rapport without even seeing each other (see for example Maxine and the mattress coordinator p.256), through the telephone and answer machines. However, in support of my earlier findings, the practitioners within this study preferred face-to-face encounters in order to achieve good communication and effective coordination of care. The importance of this was realised when a practitioner was no longer able to meet directly with others, as in the example given by Debbie (Ex.3.32, p.286). In this example, communicating directly was important to Debbie's sense of how she defined her role, and contributed to her feeling recognised and valued when she met other practitioners. So through face-to-face contacts, practitioners come to recognise their identities, clarify their own values, as well as respond to the existence and values of other practitioners.

Another notable finding was the way practitioners were delighted to meet their counterparts for the first time. This first personal encounter meant they were no longer just names on pieces of paper or voices on the telephone. Now they were able to associate a name or a voice with a person, and through it confirmed their own and colleagues self-worth and existence.

In contrast, where there had not been personal contact the existence of a service or practitioner sometimes went unrecognised (as I described earlier), and actions or contributions, went unnoticed. For instance, a lack of personal contact between the districts nurses and the acute services led to misinterpretations and a lack of understanding between services and practitioners (chapter 8, p. 200-1). Therefore, personal encounters are a way of establishing and concreting inter-professional relationships. In some cases frequent meetings strengthened these professional relationships, as practitioners began to understand the value of each other's roles and abilities.

I have illustrated in the previous chapters how personal contact and visibility between practitioners enabled a 'social dance' to take place, where practitioners were able to anticipate and negotiate each other's roles. However, it is possible for practitioners to meet regularly, and to be able to anticipate each other roles, without feeling they are part of a unified team. This was evident in Maxine's description of her relationship with the GPs in her practice (Ex. 3.3, p.255). Many of the practitioners emphasized that good teamwork or joint working necessitated more than being together and exchanging information (Barral, 1993): good team relationships depended upon personal involvement and mutual acknowledgement. This personal involvement (as a result of personal encounter) cultivated a sense of commitment and responsibility towards others. For Natalie (social care practitioner), meeting a client with other practitioners ensured this personal involvement and commitment towards each other. In this case the personnel encounter led to the discussion and initiation of actions, and improved relationships.

Likewise, practitioners recalled how personal encounters and (literally) working with others, brought about a change in attitudes towards each other. In the case of David (social care practitioner), through working closely and interacting with hospital and district nursing staff, he noticed there was a change in attitude and response towards him as his behaviour began to invalidate their notions of a social worker. Also, in the case scenario of Claire (district nurse), local organisational changes enabled her to interact with the medical and hospital staff. Over a period of time she began to experience a change in the reactions of the hospital staff towards her, and consequently was able to assert her role as a highly skilled practitioner with special community knowledge.

How does constructivist phenomenology enhance our understanding of what is happening here? In the previous study I discussed the role of experience in the loosening and tightening of constructions and how interactional experience may enable people to reconstruct their expectations and participation in events. To recap, Kelly (1977) describes the effects of experience,

*'Experience will lead us to question more freely, to be less taken in by the obvious, to see fresh possibilities of relationships, to put facts together into more productive combinations.'* (p.11)

According to Kelly, when there is a discrepancy between our anticipation of events and our construction of events, we search for more information, and hence begin the process of construct revision (Kelly, 1955). I began to see this happening during the interview process where practitioners began to recognise their own stereotypes and then review some of their evaluations of other practitioners. For instance Wendy (district nurse)

described how she had not anticipated the speedy response from the social worker, and was quite impressed by their skill and knowledge. However, she seeks further confirmation of her experience before she changes her overall view of social workers. During the interview with David, he recollects that not all GPs were 'judgmental', and through the interview technique realises in turn how he has been judgmental.

## Conclusion

To conclude, teamwork and joint working are expressed in bodily action, and involve practitioners in a common experience, through which they each confirm the experience and the value of the other parties. Through caring for the client they share similar ways of construing their experience within the community. Earlier authors suggest that to encourage good working relationships is to cultivate a movement towards a common culture between the practitioners (Tooth, 1996). It can be commented as practitioners become accustomed to working together they are indeed developing a history together, and therefore may be viewed as moving towards a type of common culture.

Nevertheless, the meaning of joint working has generated unease amongst certain practitioners for this very reason. For some practitioners a common culture may mean a loss of professional identity and specialist skills, as roles are shared and boundaries become blurred. I suggest that this may not be the case, and support the argument that practitioners need to retain their differences in expertise and perspectives in order to offer alternative and diverse strategies of care (Hudson, 2000). Rather than seeking a common culture and core ways of construing, practitioners need to consider ways that will enhance

their sociality. That is, practitioners do not need to think alike, but need to gain a mutual understanding and respect for each other's contributions to care. Collaborative working may offer the opportunities to work along side others, whilst (simultaneously) developing relationships with them freely and autonomously. Joint working, then, can become an opportunity to share each other's concerns and experiences, and to participate in each other's projects.

## **Chapter 11.**

### **Concluding reflections**

I embarked upon this project because, through my experiences as a research assistant I had become aware of the complexities and conflicts surrounding professional identities. I was therefore eager to understand what it meant to be a professional practitioner in the current climate of change, where collaborative working with other practitioners was actively encouraged. So what have I learnt about professional identities as a result of this project, and how has the constructivist phenomenological approach enhanced my understanding of professional identity?

The constructivist phenomenological approach was found to be particularly helpful in understanding the contemporary practitioner in an ever-changing environment. The combination of existential phenomenology and personal construct theory provides a strong epistemological and theoretical foundation, which encourages an alternative way of investigating professional identities and inter-professional working. This approach to study has provided me with the tools to consider how personal, historical and organisational contexts shape professional construction, and the relationships between the practitioners. In this final section I will now consider the conceptual ideas that I have generated during the course of this project and the implications these might have for inter-professional practice and research.

### **Re-construing professional identity**

My findings highlight that issues of professional identity remain important to practitioners. Like earlier authors (Tafjel, 1982, Hornby and Atkins 2000), I found that when practitioners identified with a particular occupational group, it gave them a sense of who they were, how their work was guided and valued by others. Moreover, professional identity gave practitioners a sense of how they moved, related and collaborated with others within their work. In contrast with essentialist or functional theorists (Friedson, 1983 Macdonald, 1995), I have argued that professional identity is an interactive process influenced by historic and social contingencies, and therefore it is not a fixed entity. Interestingly, both students and practitioners made references to their occupation in terms of inherent qualities. For instance, to be a district nurse or a social worker was seen by some practitioners to be a 'type of person' (Ex. 1.2. p.114, and Ex. 3. 20. p.277).

Also, many of the practitioners were keen to share the ways that they differed from other 'care' professionals in terms of their unique approach to client care and the way they worked. As you will see throughout this section (especially in the part entitled 'sedimentation') that the practitioners' comments do not describe stable, fixed characteristics, but their descriptions say something about the highly complex relationship between how practitioners are socialised, and how they make sense of their being when working with others. This is particularly illustrated by the emerging concepts of visibility and flexibility.

## **i. Visibility**

An important emerging construct throughout this project was the concept of visibility. I have defined this (broadly) as where the roles and attributes of an occupational group come to be acknowledged and validated by others - that is, come into public view. I might add, that these professional attributes may have lasting effects upon how they negotiate with their clients and other professions. Furthermore, visibility also appeared to play an important part in the process of practitioners learning to anticipate and understand each other's roles in collaborative work. I will now expand on these points drawing upon the ideas I have developed from the studies.

Above all, it was important to the practitioners that they were 'seen' by others (whether the public or other professionals) to be 'doing' a good and worthwhile job.. I am not saying that some practitioners did not enjoy the status and power that was bestowed upon them (see chapter 6, Ex.1.13. p.122) but many of the practitioners placed an importance upon how others recognised the service they provided and their commitment towards the client. Therefore, there were some attributes or aspects of their work, which the practitioners preferred to be 'visible' and others they wished to keep hidden. Often it was the favourable aspects of their work, which they were keen for others (especial the public and their clients) to know about. For instance, the student social worker commented that (only) her profession's errors were made 'visible' to the public but their 'good work' went unseen (Ex.1.9. p.120). Consequently, she believed negative public evaluation of their service adversely affected their negotiations with other professions and their clients.

Furthermore, there were particular symbols and images that would enhance an occupation's visibility in a particular way. In support of previous work (Hallum, 2000), the practitioners felt that these images had lasting impressions upon the client and the public, especially when they were taken up and portrayed by the media. Therefore, I would argue, these strong visual images strengthened 'sedimented' professional beliefs and established ways of working. For instance, the visual image of the nurse's uniform held certain lasting expectations and associations for the client. The district nurses felt the uniform helped them to gain access to the clients' homes, and enabled them to perform their roles. However, the uniform links them with their past images and roles, which may have constraining influences upon their development (see Ex.1.8. p.118; Hallum, 2000).

The findings from this project suggest that there were benefits and disadvantages associated with visibility of their roles. On the one hand visibility may enhance working practice and joint working. Practitioners might recognise the intentionality of an occupational group towards the client group, and therefore anticipate and negotiate their roles accordingly. This is illustrated by the accounts in Chapter 8 (p.200); where a service was 'unseen', and this led to misunderstandings and conflict between staff groups. However, on the other hand there were times practitioners preferred to remain invisible when, for example, they were working with 'difficult' childcare cases (Ex.1.33, p.135).

In addition, this project identified other situations in which professional roles became visible to others. I highlighted earlier that our actions are pre-reflective, and that when our usual patterns of working become problematic will we then reflect upon them.

Notably, experiencing change and conflict encouraged some of the practitioners in the studies to negotiate with other practitioners, and make them aware of their practice and involvement in care. Later, I will explore how practitioners may enhance their visibility and recognition, in order to improve their working relationships.

## **ii. Rigid roles versus flexibility**

I have found the constructivist phenomenological approach to this project particularly useful in highlighting the tension between the practitioner's need to identify with particular roles, and at the same time the need to operate and work in a flexible way. Generally, it was perceived that professional identity and consistent recognisable actions provided a sense of certainty and predictability for the practitioner (Ex.1.19. p.125). This sense of certainty served useful purposes during the course of their work. Firm professional boundaries and clearly defined roles gave a sense of autonomy over their practice, and were a counterbalance against unwanted work. I mentioned earlier, that some practitioners delighted in discussing the distinctive qualities and roles of their own occupation, which at first glance might have given the impression of clinging to 'fixed' ways of working. However it emerged from individual and group interviews that working in practice (especially with other professionals) required a level of flexibility. Often practitioners were called upon to share roles, or 'go beyond' their 'known' role, in order to provide care for the client. In such situations, rigidly adhering to fixed roles and characteristics was perceived a hindrance when working with other practitioners and with the client group. So how can we account for the paradoxes and apparent contradictions expressed by practitioners here?

I have argued in chapter two that social cognitive theories have not provided satisfactory answers to all of these questions. For instance, social identity theory (Tafjel and Turner, 1986, Festinger, 1954) highlights how a person makes comparisons and suggests that he or she somehow formulates their attitudes prior to action. However, earlier studies have suggested that relationships between attitudes and behaviour are fairly weak and that people may act quite differently to their beliefs (La Piere, 1934). Often we are in a situation when we are unable to think first, and as Merleau Ponty (1962) asserts, there are times when we think pre-reflectively or in action. In this way are thoughts are embodied, as we anticipate, interpret and respond to others in bodily movement and gestures. District nurses and social care workers may encounter a variety of different experiences, which they may not have been able to think through prior to the event, and to which they therefore respond spontaneously, according to the situation and the people that they may find themselves with. Also, I have found a number of examples within this study, where practitioners have described how they have responded to situations in ways that did not support their constructs of what it is to be nurse or a social worker. Does this mean that the social context plays a dominant role in the way we behave, and to what extent are we free agents, able to break free from social constraints?

### **Agency and change**

Some authors argue that people are so powerfully influenced by their social environment that the most effective way to change and influence behaviour is by placing them into new contexts. It is thought that the 'new' environment will *'impose new roles responsibilities and relationships upon the individual'* (Beer et al 1993, p.99). On the

contrary, my findings suggest that the sudden pressure to change may result in practitioners withdrawing into established ways of working (Biggs, 1993, Kelly, 1955), which may be counterproductive. This implies that we do not respond passively to our environment, nor do we enter into situations as blank boxes, mindlessly responding to whatever the new situation may bring. We bring to events expectations and assumptions, which may have derived from past personal experiences or traditional ways of working. These anticipations may constrain or facilitate practitioners who are called upon to modify their roles. Therefore, to encourage a change in our behaviour there are times when we need to be given the opportunity to reflect upon our position, to consider new possibilities, and to choose the roles with which we feel comfortable to adopt (Kelly, 1955).

This dilemma is exemplified in the story of the developing service, where the district nurses were re-located to a new practice base. They were expecting to continue working in the same ways they have worked, even when collaborating with other services. In one sense they felt that these familiar ways of working were nonnegotiable and were fundamental to their role as a nurse. Therefore, it is logical to assume that it is not just a profession's history or other peoples' perceptions that hold practitioners back from changing their roles, but there were certain ways of working which were perceived as fundamental to being and acting as particular practitioners. For some district nurses the change in work place had a dramatic effect on the way they moved and acted as nurse. The new location had disrupted familiar ways of working, their movements and the

smooth way of operating; like the 'disembodied woman' described by Sachs (1985), they were forced to relearn their movements and actions in a new environment.

The concept of 'sedimentation' is particularly useful here in enabling us to appreciate the apparent tension that exists between 'sedimented' roles, shaped by personal and cultural beliefs, and the more flexible ways of working presently being encouraged by NHS Trusts and the government (DOH, 2001a, 1998). Merleau Ponty writes,

*' We must recognise a sort of sedimentation of our life – an attitude towards the world, when it has received frequent confirmation, acquires a favoured status for us.'* (1962, p.441)

In some situations the pull towards established (historic) ways of working made it difficult for some practitioners to modify their roles. Often, where there is ambiguity over roles and the ways of working, practitioners may return to their old practices. Collaborative working is a good example here as there are neither known ways of working nor an established set of rules to show practitioners how to relate to each other. Therefore practitioners may resort to traditional practices because they do not know how to do anything else.

### **Understanding inter-professional relationships**

Building on what we know about 'sedimentation', how does this project add to our existing knowledge of collaborative working and team relationships? Earlier authors and practitioners have often claimed that poor inter-professional working is due to a lack of understanding of each other's roles (Hutchinson and Gordon, 1992), and both students

and practitioners in this project echoed this sentiment. I was puzzled by these findings, as collaborative working was not a new phenomenon - it had been ongoing for the past two decades! Perhaps this was a classic case of in-group and out-group conflicts, or a habitual excuse to hide behind, - a 'sedimented' type of response!

I would also argue that this lack of understanding could be partly attributed to a misconception of the term to 'understand'. Often it is construed as understanding each other's role content or to think alike (Duck, 1979). As I have discussed in the previous chapter, construing in the same way may be helpful, but enhancing sociality through visibility would be more fruitful than commonality. Duck interprets sociality as a way of understanding '*by construing others the way others construe themselves*' (p.39). Duck goes onto argue that Kelly does not specify which aspects of a person's constructs are key to understanding them. Duck then suggests that to understand a person we need to construe those areas of the person which are important to them. However, if we take the view that understanding each other's role is not confined to a cognitive knowledge, but is also embodied, then we will begin to see that it is through lived experience, and 'being with others', that practitioners will come to know and anticipate each others actions and roles (Mead, 1934, Kelly, 1955). Furthermore, to know others is to become known by others (Mair, 1977): this requires a level of transparency and of trust between people, which may involve sharing some of their weaknesses as well as their strengths. So how can staff groups be brought together to develop this form of interaction?

Perhaps one way to improve inter-professional relationships would be to increase contact between groups through organised meetings. My own research and other studies (Stephan, 1987, King and Ross, 2003,) suggest that if contact was restricted to formal circumstances there would be limited opportunity to gain an understanding of the approaches and priorities of each other's profession. Equally I would argue, if all meetings and inter-professional relationships were enforced by the organisation it is likely that people would attempt to express their individuality by resisting (see the second study) the enforcer.

Throughout this project the students and practitioners highlighted their preference for impromptu and informal meetings as an environment to develop their relationships, where they felt they could 'be' themselves. One solution then is for policy makers and managers to create environments where professionals may work along side each other, for instance locating social care offices within the same building as health practitioners. In support of earlier studies (Poxton, 1999, Hudson, 1999, Cumella, et al. 1998), I found that some of the social care assessors believed that it was through the day to day interactions of working (in the same place) would create a greater understanding of each others roles and therefore improve the sense of team work (Ex.2.34. p.224). Furthermore, it is also possible to coexist in the same working world but to continue to misunderstand each other's approaches and the way different people construe events. For instance, Maxine worked within the same practice as the GPs and did not appreciate the way GPs construed team work (Ex.3.3. p.255).

Equally, it is not guaranteed that a 'better' understanding of the way others work will naturally improve negotiations and social interactions between staff groups. What I mean by this, is that I may come to know and anticipate the way person construes in action, but I may not agree with their actions because they do not support my notions of how a person should behave. Therefore I may use tactics to avoid this person, or I may attempt to find ways to compensate for their actions. To overcome these dilemmas we need to encourage a level of engagement where practitioners have the confidence to express their views and validate each other's contributions, whilst being able to negotiate their differences and work effectively together. From my findings I suggest that this should start as early as possible, at the beginning of a practitioner's training.

### **Developing practice**

The importance of learning about each other's professional practice and values at undergraduate level are widely acknowledged (Barr, 2000,). However, as I have outlined the methods that aid reflection upon inter-professional relationships can be problematic. In support of some authors I contend that an active element of interaction is important at an early stage in undergraduate training (Miller et al. 2001), where the issues of professional identity may be tackled directly. This may be in the form of field experiences where inter-professional learning takes place in the day-to-day experiences of joint working. For example, students and practitioners might 'shadow' other practitioners within their work place. Outside of the practice context, whether it was part of a workshop or classroom situation the reflective interview techniques (utilised in the last study) was found to be an effective way in encouraging students and practitioners to

reflect upon inter-professional relationships. I then adapted the interpersonal network techniques (Hargreaves, 1979) and the Salmon Line for use in classroom teaching, with the potential to be used in clinical professional development.

### **Experiences from use in teaching**

I employed the reflective interview techniques on a number of occasions as a classroom exercise. In one example, it was incorporated into a module on collaborative working for post-registration nurses undertaking a specialist qualification in community nursing. Students presented scenarios from their own working experience to their peers, using the layout and Salmon Line, with the teacher acting as a facilitator. So far this has proved fruitful, with students presenting complex inter-professional situations to other students. I found that students were enabled to engage in critical reflective evaluations at every stage of the process, from choosing a joint working scenario, to reflecting on how they believed other practitioners defined their roles and relationships within the chosen event. I had positive feedback from the students who participated in this exercise. One student district nurse commented on how the experience gave them fresh insight into the situation, and had led her to question her relationships with other professionals.

### **Clinical professional development**

The practitioners I interviewed using this technique found the layouts revealing and some were amazed at the complexity of their involvement with other practitioners. They also found the task useful in taking an overview of very complex cases that needed input from many other practitioners. In particular, Maxine went on to say how she would like to use

this method to help her organise care provided in collaboration with other team members. Significantly, I found the interview process encouraged practitioners to reflect upon their own stereotypical attitudes, and how in some cases these may have impeded interpersonal relationships. Also, participants became aware of how they might improve some of their 'poor' relationships with other practitioners, particularly those from the hospital services. Often these attitudes had developed where there was no contact between staff groups or where the contact that was made usually concerned complaints. To improve these relationships the exercise highlighted how the practitioners had to initiate action rather than wait for a service to contact them. Maxine for example, suggested visiting a ward on a regular basis. Other suggestions made included inviting themselves to hospital case conferences, and 'shadowing' other practitioners: by these means the practitioners felt they would be able to meet other staff, and share their different perspectives towards client care.

## **Strengths and limitations**

At this point I would like to reflect upon the strengths and weaknesses of the underpinning approach to this project, and the overall benefits of undertaking this work.

The constructivist phenomenological approach I have taken, aims to explore how practitioners experience their world, how they give meaning and purpose to their work, as it appears to them. I have sought to provide a description rather than an explanation, as I believe description powerfully enhances understanding by presenting alternative viewpoints that may lead to action. I hope that through reading this project, and pondering over the experiences it describes, and the issues it raises practitioners will reflect upon their own inter-professional relationships, the meanings that they assign to their work practices and their possible shortcomings. Perhaps such reflections will lead to exploring alternative ways of construing their professional identity and their professional relationships.

The studies presented in this project provide a snapshot of a particular time in a particular context, and therefore cannot be generalised in the same way as quantitative studies. For example, the students at Houghton University may not share the same experiences as other student practitioners from other universities. Different contexts and experiences may evoke different responses and reactions. For instance, many of the experiences described here largely refer to a white, female population (see Appendix – reflexive notes). However, it is hoped that the level of detail provided in this project would enable the reader to recognise and evaluate whether the experiences described here

may be relevant to their own context (Seale, 1999). It might be possible for others to draw upon the principles outlined here and transfer them to other situations which share similar characteristics. Although I have chosen to write about district nurses and social care practitioners, some of the issues raised concerning professional identity in collaborative events may arise in other collaborative situations and in other organisations that are undergoing similar changes and developments.

A possible limitation of this project is that it largely relies upon texts from semi-structured interviews to gain access to meanings and to form the accounts. It is questionable whether interviews enable researchers to access practitioners' meanings or to access the ways practitioners' construe their identity (Willig, 2000). It can be argued that language constructs, rather than describes reality, and that an interview tells us more about the way a person talks than about their experiences (Burr, 2002). Also, it is questionable whether people are able to articulate what they mean and what they experience within an interview. In response to these complex questions I support the notion that language plays an important role in constructing meaning, but also I take the view that there is a relationship between what people say in an interview and what they experience. That is to say, language is a tool by which internal reflections may be 'externalised' (Mead, 1934). Kelly asserts that we are able to reflect upon our experiences, and express these verbally and in action. Therefore it is possible through the art of listening to the 'subtle undertones of language' to become accustomed to the language of care practitioners and the meanings they ascribe to their life world (Van Manen, 1992).

Nevertheless, there were times when it was difficult for participants to articulate how they felt about their work and their inter-professionals relationships, which illustrates further how many of our activities and interactions are embodied. However these interviews were supported by focus groups, the Hargreave's interpersonal network and Salmon Line interview techniques, which encouraged participants to reflect upon their interactions. I believe this gave breadth to the study, as well as insights into how identity was negotiated within a group as well as within an individual.

Equally, within this project I have attempted to demonstrate how like others, I am influenced by my historical and social background, and how this may have impacted upon my interviewees and affected the responses I elicited from them. To counterbalance these influences, the phenomenological tools and the template analysis were useful methods in helping to maintain a critical stance when interviewing, and when dealing with the data. However, at times this was problematic, as I found I would empathise with the participants to a degree that it would be difficult to critically 'stand back'. In this way my colleagues, supervisors and those who were involved in the project helped me not to become so embroiled in the analysis, and were able to offer opinions that challenged my own. Additionally, I hope that through incorporating my reflexive accounts within the different studies will enable the reader to determine how my interpretations were drawn.

## **Final note**

Overall, I have found the constructivist phenomenological approach to examining experiences of collaborative working valuable in both research and teaching. The combination of existential phenomenology and personal construct theory provide a strong theoretical foundation. This position is less prescriptive than essentialist accounts and acknowledges the personhood of the individual as well as the social processes that might influence the person.

Concerning the data collection methods, in particular I enjoyed using the reflective interview techniques (Hargreave's interpersonal network and Salmon Line). These were such versatile and powerful tools, and appeared to be highly acceptable to the professionals I have used them with. In using these methods, participants were able to provide me with a detailed account of their interactions with other professionals. This helped me, as an 'outsider', to grasp the complexities of the practitioner's role within a joint working event.

From my experience of other projects in this area, I feel confident that the techniques employed here facilitated the elicitation of a more thorough account than I might have obtained using traditional semi-structured interviews. Specifically, the layout and Salmon Line encouraged the different practitioners to consider a wider range of co-workers than they might have without the use of these reflective tools. For example, the conversation tended to focus upon those whom the participants had intense relationships with. These would be practitioners placed at end of the dimension scale, where relationships were

very positive or where relationships were significantly poor. However, I was able to prompt them concerning those practitioners who fell between the extremes and say 'what about this person or team?'

In future I would like to extend the use of these reflective methods to the everyday practice of professionals working in multi-disciplinary settings. For example, as a part of team development activities, members could utilise visual layouts to share how they perceive the different relationships within a team. The Salmon Line could be used to explore ways of improving professional relationships, and ways of helping teams to achieve their identified goals. At a another level, I would also be keen to see the constructivist phenomenological methodology and methods extended to a wider range of research and teaching settings in health and social care - especially in areas where cross cultural groups are perceived to be difficult. For instance, exploring the changing professional relationships and boundaries between the acute hospital and primary care staff.

## References

Abel-Smith, B. (1979) *A History of the Nursing Profession*, Frome and London: Butler and Tanner Ltd.

Abbott, P. and Meerabeau, L. (1998) Professionalisation and the caring professions, in P. Abbott, and L. Meerabeau (eds.) *The sociology of the caring professions 2<sup>nd</sup> edition*, London: UCL Press. 1-19.

Abrams, D. and Hogg, M.A (1988) Comments on the motivational status of self-esteem in social identity and inter-group discussion. *European Journal of Social Psychology*, **18**: 317-34.

Abrams, D. and Hogg, M.A. (1991) An introduction to the social identity approach in D.Abrams and M.A (eds.) *Social Identity Theory: Constructive and Critical Advances*, London: Harvester Wheatsheaf. 1-9.

Achterberg, J. (1990) *Women As Healer*, Massachusetts: Shambhala Publications Inc.

Addison, R. B. (1999) A Grounded Hermeneutic Editing Approach, in B.F.Crabtree and W.L. Miller (eds.) *Doing Qualitative Research*, 2<sup>nd</sup> Edition, London: Sage Publications inc. 145-161.

Alderfer, C.P. and Smith, K.K. (1982) Studying Intergroup Relations Embedded in Organizations, *Administrative Science Quarterly*, **27**: 35-65.

Argyle, M. (1989) *The Social Psychology of Work* 2nd edition, London: Penguin.

Argyle, M. (1994) *The psychology of Interpersonal Behaviour*, London: Penguin.

Audit Commission. (1999) *First Assessment a review of district nursing services in England and Wales*, London: Belmont Press.

Baly, M.E. Robottom, B., and Clark, J.M. (1987) *District Nursing* 2<sup>nd</sup> edition, Oxford: Heinmann Professional Publishing Ltd.

Barbour, R.S. (1999) Are focus groups an appropriate tool for studying organisational change? in R.S. Barbour and J. Kitzenger (eds) *Developing Focus Groups*, London: Sage.113-126.

Barr, H. (2000) *Inter-professional Education Today, Yesterday and Tomorrow: A review* commissioned by The learning and teaching Support Network for Health Science and Practice from the UK Centre for the Advancement of Inter-professional Education.

Available: [http://www. Health.Itsn.ac.uk/miniprojects/HughBarrFinal.htm](http://www.Health.Itsn.ac.uk/miniprojects/HughBarrFinal.htm).

Barral, M.R. (1993) *Self and Other: Communication and Love*, in K.Hoelle (ed) *Merleau Ponty and Psychology*, New jersey: Humanities Press.

Beattie, A. (1995) War and peace among the health tribes in K. Soothill, L. Mackay and C. Webb (eds) *Inter-professional Relations in Health Care*, London: Edward Arnold. 11-18.

Beauchamp, T. L., and Childress, J.F. (1994) *Principles of Biomedic Ethics*, NY, Oxford: Oxford University press.

Becker, C. (1992) *Living and relating: An introduction to phenomenology*, London: Sage.

Beer, M Russell, A., E., and Spector, B. (1993) Why change programmes don't produce change? in C. Mabey and B. .Mayon-White (eds) *Managing Change*, 2<sup>nd</sup> edition, London: The Open University. 99- 107.

Berger P. L., and Luckmann, T. (1967) *The social construction of reality; a treatise in the sociology of knowledge*, London: Allen Lane.

Bersoff, D.N. (1995) *Ethical Conflicts in Psychology*, Washington: American Psychology Association.

Biggs, S. (1993) User participation and Inter-professional Collaboration in Community Care. *Journal of Inter-professional Care*, 7 (2): 151-159.

Biggs, S (1997a) Inter-professional collaboration: problems and prospects, in J. Ovreteit, P. Mathias and T. Thompson, *Inter-professional Working for Health and Social Care*. London: Macmillan. 186 – 200.

Blane, D. (1991) Health Professions, in G. Scrambler (ed.) *Sociology as Applied to Medicine*, London: Bailliere Tindall. 221-235.

Bloor, M (1997) Techniques of validation in qualitative research: A practical commentary, in G. Miller, R, Dingwall (eds) *Context and Method*, London: Sage. 37-50

Bloor, M., Frankland, J., Thomas, M., and Robson, K. (2001) *Focus groups in Social Research*. London: Sage Publications.

Blumer, H (1969) *Symbolic Interactionism*, Englewood Cliffs. NJ:Prentice Hall.

Booth, T.A. (1981) Collaboration between the health and social services: Part1, A case study of joint care planning, *Policy and Politics*, 9 (1): 23-49.

Bottella, L. (2000) *Personal Construct Psychology, Constructivism and Postmodern thought*. Hrl: <http://www.massey.ac.nz/~ALock/virtual/Construc.htm>. retrieved (20/6/00).

Brandon, J. (1998) The monastic tradition and community care in R. Jack (ed.) *Residential versus Community Care: the role of institutions in welfare provision*. London: Macmillan Press Ltd. 112- 123.

Brown, R.B, and McCartney S. (2000) Professionalism definitions in ‘managing’ health services: perspectives on the differing views of clinicians and general mangers in an NHS Trust, in E. Malin (ed.) *Professionalism, Boundaries and the Workplace*. London: Routledge. 178-194.

Burch, S., and Borland, C. (2001) Collaboration, facilities and communities in day care services for older people, *Health and Social Care in the Community*, **9** (1):19-30.

Burr, V. (2002) *The person in social psychology*, Hove, NY: Psychology Press.

Burr, V., and Butt, T.W. (1997) *Interview Methodology and Personal Construct Psychology*, proceedings of EPCA Conference, Reading.

Butt, T. (1996) “PCP: Cognitive or social psychology?” in J.W. Scheer and A.Catina (eds.) *Empirical Constructivism in Europe, The Personal Construct Approach*. Giessen: Psychosozial-Verl. 58-65.

Butt, T. (1997) Sedimentation and Elaborative Choice, *Journal of Constructivist Psychology*, **11**: 265-281.

Butt, T. (1998) Sociality, role and Embodiment, *Journal of Constructivist psychology*,**11** :105-116.

Butt, T. (2004) *Understanding People*, Basingstoke: Palgrave Macmillan

Callaghan, G Exworthy, M. Hudson, B.,and Peckham, S. (2000) Prospects for collaboration in primary care: relationships between services social services and the new PCGS. *Journal of Inter-professional Care*, **14** (1): 19-26.

Chiari, G., and Nuzzo, M.L. (1996) Psychological Constuctivisms: A Metatheoretical Differentiation, *Journal of Constructivist Psychology*,**9** :163-184.

Crabtree, B.F., and Miller, W. L. (1999) Research practice Settings: A case study approach, in B.F.Crabtree and W.L. Miller (eds) *Doing Qualitative Research* 2<sup>nd</sup> Edition, London: Sage Publications inc. 293-312.

Crotty, M. (1998) *The foundations of Social Research: Meaning and Perspective in the Research Process*. London: Sage publications.

Cumella, S., le Mesurier, and Tomlin, H. (1998) *Social work in Practice: An evaluation of the care management received by elderly people from social workers based in GP practices in South Worcestershire*, The Martley Press.

Davies, HT and Nutley, S.M. (2000) Organisational culture and quality of health care, *Quality in Health care*, 9 :111-119 <http://qhc.bmjournals.com/cgi/content/full/9/2/111> accessed 29/04/2002.

Dingwall, R., Rafferty, M.,and Webster, C. (1988) *An Introduction to the Social History of Nursing*, London: Routledge.

D.O.H. (1989) *Caring for people: Community Care in the next decade and beyond*. London: H.M.S.O.

D.O.H. (1990) *The Community Care Act*, London: H.S.M.O.

D.O.H. (1998) *Partnership in Action, discussion document*, London: H.S.M.O.

D.O.H. (1997) *The New NHS Modern and Dependable*. London: H.M.S.O.

D.O.H. (1999) *Health Act Section 31 Partnership Arrangements*, London H.S.M.O.

[www.doh.gov.uk/partnership.htm](http://www.doh.gov.uk/partnership.htm) retrieved 3/4/00 14.49.

D.O.H. (2001a) *Shifting the balance of power within the NHS*, London: H.M.S.O.

D.O.H. (2001b) *Research Governance Framework for Health and social care*, London: HSMO.

Dolan, J. A., Fitzpatrick, M., L., and Herrmann, E.K. (1983) *Nursing in Society: A historical perspective*, East Sussex: W.B. Saunders Company.

Dombeck, M-T. (1997) Professional Personhood: training territoriality and tolerance, *Journal of Inter-professional care* ,**11** (1): 9-21.

Duck, S (1979) The personal and Interpersonal in Construct Theory: Social and Individual Aspects of Relationships, in P. Stringer and D. Bannister (eds.) *Constructs of Sociality and Individuality*, London: Academic Press. 279-298.

Duck, S (1983) Sociality and Cognition in personal construct theory, in J. Adams-Webber and J.C. Mancuso (eds.) *Application of Personal Construct Theory*, London: Academic Press.

du Preez, P. (1979) Politics and Identity in South Africa, in P. Stringer and D. Bannister (eds.) *Constructs of Sociality and Individuality*, London: Academic Press. 341-364.

Easton, L., Fry,J., McCormish, Greenberg, R (2000) Avoiding Common Pitfall in Qualitative Data Transcription, *Qualitative Health Research*, 703-707.

Evetts, J. (1999) Professionalisation and professionalism: issues for inter-professional care, *Journal for Inter-professional care*, **13** (2): 119-128.

Festinger, L. (1954) A Theory of Social Comparison Processes, *Human Relations* **7**:117-140.

Finlay, L. (2000) The Challenge of Professionalism, in A. Brechin, H. Brown and M. A. Eby (eds) *Critical Practice in Health and Social Care*, London: Sage publications.73-95.

Flick, U. (1999) *An Introduction to Qualitative Research*, London: Sage Publications.

Fontana, A., and Frey, J.H. (1994) The Art of Interviewing, in N.K. Denzil and Y. S. Lincoln (eds) *Handbook of Qualitative Research*, London: Sage Publications Inc. 361-376.

Fournier, V. (2000) Boundary work and the (un) making of the professions, in E. Malin (ed.) *Professionalism, Boundaries and the Workplace*, London: Routledge. 67-86.

Friedson, E. (2001) *Professionalism the third logic*, Cambridge:Polity.

Freidson, E. (1983) The theory of Profession: State of the Art, in R.Dingwall and P.Lewis (eds.) *The Sociology of the Professions Lawyers, Doctors and others*, London: Macmillan. 19-37.

Gabriel, Y. (1998) The use of Stories, in G. Symon and C. Cassell (eds.) *Qualitative Methods and Analysis in Organisational Research*, London: Sage. 135-160.

Gelman, S.B., White, A.W., Carlson, L., and Norman, L. (2000) Making Organizational Change to Achieve Improvement and Inter-professional Learning: Perspectives from Health Professions Educators, *Journal Of Inter-professional care*, **14** (2): 131-146.

Gergen, K, J. (1997) *Realities and Relationships: Soundings in Social Construction*. London: Harvard University Press.

Gibbs, G. R. (2002) *Qualitative data Analysis: Explorations with Nvivo*, Buckingham; Open University Press.

Gilchrist, V. J., Williams, R.L. (1999) Key informants, in B.F. Crabtree and W.L. Miller (eds.) *Doing Qualitative Research*, 2<sup>nd</sup> Edition, London: Sage Publications inc.71-88.

Glendenning, C., Rummery, K., and Clark, R. (1998) From collaboration to commissioning: developing relationships between primary health and social services, *BMJ*, **317** :122-125

Goodman, C. (2001) The use of metaphor in district nursing: maintaining a balance, *Journal of Advanced Nursing*, **33** (1): 106-112.

- Gorman, P. (1998) *Managing multidisciplinary teams in the NHS*. London: Kogan.
- Griffiths, R. (1988) *Community care: Agenda for Action*. London, H.S.M.O.
- Guba, E.C. (1990) The alternative paradigm dialog, in E.G. Guba (ed.) *The Paradigm Dialog*, London: Sage Publications. .17-27.
- Guest, D.E. (1984) Social Psychology and Organisational change, in M.Gruneberg and T. Wall (eds.) *Social Psychology and Organizational Behaviour*, New York: John Wiley and Sons. 183-225.
- Guzzo, R.A. (1996) Fundamental Considerations about Work Groups, in M.A.West (ed.) *Handbook of workgroup psychology*, Chichester: Wiley. 3-21.
- Hallum, J. (2000) *Nursing The Image; media culture and professional identity*. London: Routledge.
- Hargreaves, C.P. (1979) Social Networks and Interpersonal Constructs, in P. Stringer and D. Bannister (eds.) *Constructs of Sociality and Individuality*, London: Academic Press. 153-175.
- Harré, R. (1979) *Social being a theory for social psychology*, Oxford: Blackwell.

Hartley, J.F. (1996) Intergroup relations in Organizations, in M.A.West (ed.) *Handbook of Workgroup Psychology*, Chichester: Wiley. 397-422.

Higgins, R. Oldman, C., and Hunter, D.J. (1994) Working together: Lessons for collaboration between health and social services, *Health and Social Care* 2: 269-2.

Hogg, M., and Abrams, D. (1999) *Social Identifications: A Social psychology of intergroup relations and group processes*, London: Routledge.

Hogg, M.A., and Abrams, D (1990) Social motivation, self-esteem and social identity, in D. Abrams and M.A (eds.) *Social Identity Theory: constructive and Critical Advances*, London: Harvester Wheatsheaf. 28-47.

Holland, R. (1970) George Kelly: Constructive Innocent and Reluctant Existentialist, in D. Bannister. (ed.) *Perspectives in Personal Construct Theory*, London: Academic Press. 111-132.

Holloway, I., and Wheeler, S. (2002) *Qualitative Research in Nursing*, Oxford: Blackwell Publishing.

Homby, S. (1998) *Collaborative care*, London: Blackwell Science LTD.

Hornby S., and Atkins, J. (2000) *Collaborative care Inter-professional Interagency and inter-professional* London: Blackwell Science LTD.

Horner, N. (2003) *What is Social Work? Context and Perspectives* , Exeter: Learning Matters LTD.

Hoskins, D.M., and Morley, I.E. (1991) *A social psychology of organizing: People, processes and contexts*, NY and London: Harvester Wheat sheaf.

Hudson, B. (1998) "Prospects of Partnership", *Health Service Journal*, **16 April**: 26-27.

Hudson, B (1999) Primary health care and social care: working across professional boundaries, Part one; The changing context of inter-professional relationships, *Managing Community Care* **7** (2): 15-22.

Hudson, B (2000), in A Brechin, H Brown and M.,A.Eby (eds.) *Critical Practice in Health and Social Care*. London: Sage publications. 253-274.

Husserl, E. (1931/1980 reprint) Fact and Essence, in R.C. Solomon (ed.) *Phenomenology and Existentialism*, Washington: University Press of America. 253-258.

Husserl, E. (1930) The phenomenology of Edmund Husserl: The Paris Lectures, In R.C. Soloman (ed.) *Phenomenology and Existentialism*, London & Boston: University press of America,Inc. 43-282.

Hutchinson, A., and Gordon, S. (1992) Primary Care Teamwork- making it a reality, *Journal of inter-professional Care*, 6 (1): 31-42.

Johnson, G. (1993) Processes of managing strategic change, in C. Mabey and B. Mayon White (eds.) *Managing change*, 2<sup>nd</sup> edition, London: Chapman Publishing LTD.59-84.

Johnston, L., and Hewstone, M. (1991) Intergroup contact: Social identity and social cognition, in D. Abrams and M.A Hogg (eds.) *Social Identity theory: Constructive and Critical Advances*, London: Harvester Wheatsheaf. 185-210.

Jolley, M. (1989) The professionalisation of nursing: the uncertain path, in M. Jolley M and P. Allen. (eds.) *Current issues in Nursing*, London: Chapman and Hall .1-17.

Jordan, B. (1997) Social work and Society, in M. Davies (ed.) *The Blackwell Companion to Social work*. Oxford: Blackwell Publishers Ltd. 8-23.

Kelly, G. A. (1955) *The Psychology of personal Constructs , Volume one: A theory of Personality*, New York: WW Norton and Company inc.

Kelly, G.A. (1967) *The Psychology of the Unknown*, in D Bannister (ed) *New Perspectives in personal Construct theory*, London & New York: Academic Press. 1-79.

Kelly, G. A. (1991) *The Psychology of Personal Constructs, Volume two: Clinical diagnosis and psychotherapy*, London: Routledge.

Kelly, A., Mabbett,, and Thome, R. (1998) *Professions and Community Nursing*, in A. Symonds and A. Kelly (eds.) *The social construction of community care*, Basingstoke:Macmillan.

Kimmel, A.J. (1988) *Ethics and values in applied social research* London: Sage publications.

King, E. (1998) *The use of Self in qualitative research*, in J.T.E, Richards (ed) *Handbook of Qualitative research methods for psychology and social science*. 175-188.

King, N. (2003) *Involvement in innovation: the role of identity*, in L.Shavinina (ed.) *International Handbook on Innovation*. New York: Elsevier Science.

King, N. (2004) *Using templates in the thematic analysis of text*, in C.Cassell and G.Symon (eds.) *Essential Guide to Qualitative Methods in Organizational Research*. London: Sage.

King, N., and Anderson, N. (1995) *Innovation and Change*, London: Routledge.

King, N., and Ross, A. (2003) Professional Identities and Inter-professional Relations: Evaluation of Collaborative Community Schemes, *Social work in Health Care*, **38**, (2) 5 :1-72.

King, N., Ross, A., Firth, J., and Arevalo, M., (1999) *Evaluation of the Fast Response Scheme: Part one – Staff reactions*. Unpublished report. PCRG. University of Huddersfield. UK.

Kitzinger, J. (1996) Introducing focus groups, in N. Mays and C. Pope (eds.) *Qualitative Research in Health Care*, London: BMJ Publishing Group.

Kitzinger, J., and Barbour, R.S. (1999) Introduction: the challenge of focus groups, in R.S. Barbour and J. Kitzinger (eds.) *Developing focus Group Research*, London: Sage Publications. 1-20.

Koocher, G.P., and Keith-Spiegel, P. (1998) *Ethics in Psychology: Professional standards and cases*, Oxford: Oxford University Press.

Kraus, W.A. (1980) *Collaboration in Organizations : Alternatives to Hierarchy*, NY and London: Human Sciences Press.

Kvale, S. (1996) *InterViews : An introduction to Qualitative Research Interviewing*,

London: Sage publications.

Kvale, S. (1995) The Social Construction Of validity, *Qualitative inquiry*, 1 (1) p.19-40.

Laming Lord, (2002) The Victoria Climbié Inquiry. Norwich HMSO. Available:  
<http://www.victoria-climbié-inquiry.org.uk/finreport/introduction.htm>

Lapadat, J.C., and Lindsay, A.C. (1999) Transcription in Research Practice: From Standardisation of technique to Interpretative Positionings, *Qualitative Inquiry*, 56 (1) : 64-86.

La Pièrre, R.T. (1934) Attitudes versus actions, *Social Forces*, 13, 230-277.

Larsen, M.S. (1977) *The Rise of Professionalism; a sociological analysis*, Berkeley London: University of California Press.

Leathard, A. (1994) Inter-professional developments in Britain: an overview, in A. Leathard (eds.) *Going Inter-Professional: Working Together for Health and Welfare*, London: Routledge.3-37.

Leitner, L. (1985) Interview Methodologies for Construct Elicitation: Searching for the Core, in F.Epting and A.W. Landfield (eds.) *Anticipating Personal Construct Psychology*, Lincoln and London: University of Nebraska Press. 292-305.

LeVasseur, J.J. (2003) The Problem Of Bracketing in Phenomenology, *Qualitative Health Research*, **13** (3): 408-420.

Limb, M. (1998) Creaking Joints, *Health service journal* 5th November.

Lincoln, Y.S., and Guba, E.C. (1985) *Naturalistic Inquiry*, Newbury Park California: Sage.

Lincoln, Y.S., and Guba, E.C. (2000) Paradigmatic controversies, contradictions and emerging confluences, in N.K. Denzin and Y.S. Lincoln (eds.) *Handbook of Qualitative Research* 2<sup>nd</sup> edition, London: Sage Publications.163-188.

Lymbery, M. (2000) The retreat from professionalism, in E. Malin (ed.) *Professionalism, Boundaries and the Workplace* London: Routledge.123-138.

Macdonald, K.M. (1995) *The Sociology of Professions*. London: Sage publications.

Mackay, N. (1997) Constructivism and the logic of explanation, *Journal of Constructivist Psychology*, **10**: 339-361.

Mair, J.M.M. (1977) The community of self, in D.Bannister (ed.) *New Perspectives in Personal Construct Theory*, London and New York: Academic Press. 125-149.

Malin, N. (2000) Professionalism and Boundaries of the former sector: the example of social and community care”, in E. Malin (ed.) *Professionalism, Boundaries and the Workplace*, London: Routledge.7-24.

Mays, N. (1991) Community Care, G. in Scrambler (ed) *Sociology as applied to medicine*, London: Balliere Tindall.

Mays, N., and Pope, C. (1996) Rigour and Qualitative research, in N. Mays and C. Pope (eds.) *Qualitative Research in Health Care*.10-19.

Mead, G.H. (1934) *Mind Self and Society*, Chicago and London: The University of Chicago Press.

Merleau - Ponty, M. (1962) *Phenomenology of Perception*, London: Routledge.

Miller, W.L. and Crabtree, B.F. (1999) Clinical Research: A Multimethod Typology and Qualitative Roadmap, in B.F.Crabtree and W.L. Miller (eds.) *Doing Qualitative Research*, 2<sup>nd</sup> Edition, London: Sage Publications inc. 3-30.

Miller, C., Freeman, M., and Ross, N. (2001) *Inter-professional Practice in Health and Social Care*, London: Arnold.

Morgan, D. L., and Krueger, A. (1993) When to use focus groups and Why, in D.L.

Morgan (ed.) *Successful Focus Groups: Advancing the State of the Art*, London: Sage Publications.3-19.

Molyneux, J. (2001) Inter-professional team working: what makes a team work well? *Journal of Inter-professional Care*, **15** (1): 29-35.

Moustakas, C. (1994) *Phenomenological research Methods*, California and London: Sage Publications.

Murphy E., Dingwall, R., Greatbatch, D., Parker, S., and Watson, P. (1998) *Qualitative research methods in health technology assessment: a review of the literature*, Basingstoke: The Basingstoke press.

Musson, G. (1998) Life Histories, in G. Symon and C. Cassell (eds.) *Qualitative Methods and Analysis in Organisational Research*, London: Sage.10-27.

Nkomo, S.M. and Cox, J.R. (1995) Diverse Identities, in S. R..Clegg, S. Hardy and W.R. Nord (eds) *Organisations in Managing Organisations: current Issues*, London: Sage. 88-104.

Ovretveit, J. (1994) *Coordinating Community care*, Buckingham: Open University Press.

Parrott, L. (1999) *Social work and Social Care*, Eastbourne: The Gildredge Press LTD.

Parsloe, P. (2001) Looking back on social work education, *Social Work Education*, **20** (1): 9-19.

Pettigrew, A., Ferlie, E., and McKee, L. (1992) *Shaping strategic change: making change in large organizations: The case of the National Health Service*, London: Sage.

Pietroni, P and Pietroni, C. (1996) *Innovations in Community Health and Primary Care- The Marylebone Experiment*, London: Churchill Livingstone.

Pizurki, H., Alfonsa, M., Butler, I., and Ewart, L. (1987) *Women as providers of health care*, NY: World Health Organization Publications.

Plummer, K. (1995) Life Story Research, in J.A. Smith, R. Harre and L. Langenhove (eds) *Rethinking Methods in Psychology*, London: Sage. 50-63.

Polkinghorne, D. E. (1992) Postmodern Epistemology of Practice, in S. Kvale (ed.) *Psychology and Postmodernism*, London: Sage Publications. 146-165.

Poxton, R. (1999) *Partnerships in Primary and Social Care: integrating services for vulnerable people*, London: Kings Fund Publishing.

Rawson, D. (1994) Models of inter-professional work, likely theories and possibilities, in A. Leathard (ed) *Going Inter-professional: Working Together for Health and Welfare*, London: Routledge.

Reed, J and Proctor, S. (1993) *Nurse education- A reflective Approach*, London: Edward Arnold.

Rollinson, D., Bradfield, A., and Edwards, D.J. (2002) *Organisational Behavioural Analysis : An integrated approach*, 2<sup>nd</sup> edition, Harlow: Financial Times Prentice Hall.

Ruch, G. (2002) From Triangle to Spiral: Reflective practice in Social work education, Practice and Research, *Social Work education*, 21, (2) :199-216.

Rummery, K. (1999) The way forward for joint working? Involving primary care in the commissioning of social services, *Journal of inter-professional care*, 13 (3): 207-217.

Rummery, K., and Glendining, C. (1997) *Working Together*, Manchester: National Primary Care Research and Development Centre.

Salmon, P. (1984) 'grids are all very well, but....' *European Personal Construct Association Newsletter*.

Salmon, P. (2003) A psychology for teachers, in F.Fransella (ed) *International Handbook of Personal Construct Psychology*, Chichester: John Wiley. 311-318.

Sacks, O. (1985) *The Man Who Mistook His Wife for a Hat*, London: Picador.

Schwandt, T. A. (1994) Constructivist, Interpretist approaches to human inquiry, in N.K. Denzin and Y. S. Lincoln (eds) *Handbook of Qualitative Research*, London Sage Publications. 118 –137.

Schwandt, T.A. (2003) Three Epistemological Stances for qualitative Inquiry: Interpretivism, Hermeneutics, and Social Constructionism, In N.K. Denzin and Y.S. Lincoln (eds.) *The Landscape of Qualitative Research Theories and Issues*, London: Sage Publications. 292-331.

Scott, W.R. (1969) Professional employees in a bureaucratic structure: Social work, in A. Etzioni (ed.) *The semi- professions and their organisations*, New York: Free press. 82-140.

Seale, C. (1999) Quality in Qualitative Research, *Qualitative Inquiry*, 5 (4): 465-478.

Sheppard, M. (1992) Contact and Collaboration with General Practitioners: A comparison of social workers and community Psychiatric Nurses, *Br. Journal of Social Work*, 22: 419-436.

Sherif, M. (1964) *Reference groups: exploration into conformity and deviation of adolescents*. London: Harper Row.

Sherif, M. (1981) *Experimental study of positive and negative intergroup attitudes between experimentally produced groups*. Oklahoma: Strong and Robinson.

Sheriff, M and Sherif M. (1967) *Group conflict and Co-operation* London: Routledge and Kegan Paul Ltd.

Shotter, J. (1993) *Conversational realities: Constructing life through language*, London: Sage.

Silverman, D. (2000) *Doing Qualitative Research; A Practical Handbook*, London: Sage Publications.

Sims, J., Rink, R., Walker, R., and Pickard, L. (1997) The introduction of a hospital at home service: a staff perspective, *Journal of inter-professional Care*, **11** (2):217-224.

Smith, J. (1995) Semi Structured Interviewing and Qualitative Analysis, in J.A. Smith, R.Harre and L. Langenhove (eds) *Rethinking Methods in Psychology*, London: Sage. 9-26.

Smith, J.A., Jarman, M., and Osborn, M. (1999) Doing Interpretative Analysis In M Murray and Chamberlain, K. (eds.) *Qualitative Health Psychology, theories and methods* London: Sage Publications. P 218-240

Spinelli, E. (1989) *The interpreted world*. London: Sage Publications.

Spurling, L. (1977) *Phenomenology and the social world: the philosophy of Merleau-Ponty and its relation to the social sciences*, London: Routledge and Kegan Paul.

Stephan, W.G. (1987) The contact hypothesis in intergroup relations, in C. Hendrick (ed.) *Review of personality and social psychology*. Newbury Park, CA: Sage. 9: 13-40.

Stuart, G. (2002) Embedding practice based, Inter-professional education into the curriculum. [www.swap.ac.uk/casestudy](http://www.swap.ac.uk/casestudy)

Tajfel, H and Turner, J.C. (1986) The Social Identity of Intergroup Behaviour, in S. Worschel (ed) *The Social Psychology of Intergroup Relations*, Montsey, CA: Brooks – Cole. 33-47.

Taylor, D.M., and Moghaddam, F. (1994) *Theories of Intergroup relations; International Social psychological perspectives*, 2<sup>nd</sup> edition, Westport: Praeger Publishers.

The British Psychological Society, (2000) *Code of conduct, ethical principles and guidelines*, Leicester: The British Psychological Society.

Tooth, B (1996) Group construing: The impact of professional training, in D. Kalekin-Fishman and B.M. Walker (eds.) *The construction of group realities culture, society and personal construct theory*, Malabar Florida: Kreiger Publishing Company. 243-265.

Toren, N. (1969) Semi-professionalism and social work: A theoretical perspective, in A. Etzioni (ed.) *The semi- professions and their organisations*. New York: Free press. .82-140.

Turner, J.C. (1991) *Social Influence, Bucks: Open University Press*.

Turniansky, B., and Hare A.P. *Individual and groups in Organisations*, London: Sage Publications.

United Kingdom Council for Nursing Midwifery and Health Visiting, (1996) *Guidelines for professional practice, London: UKCC*.

Valle, R.S., King, S., and Halling, S. (1989) An Introduction to Existential-Phenomenological Thought in Psychology, in R.S. Valle and S. Halling (eds) *Existential-Phenomenological Perspectives in Psychology: Exploring the Breadth of Human Experience*, New York : London: Plenum Press.

Van Manen, M. (1992) *Researching Lived Experience, Human Science for an action sensitive pedagogy*, Ontario: The Althouse Press.

Warren, B. (1998) *Philosophical Dimensions of Personal Construct psychology*, London and New York; Routledge.

Webb, D. A. (1997) *The teamwork experience: An investigation into the personal constructs of shift managers, team leaders and team members*: Unpublished Masters Dissertation, University of Sheffield.

White, R. (1978) *Social Change and The Development of the Nursing Profession: A study of the Poor law Nursing Service 1848-1948*, London: Henry Kimpton Publishers.

Whittington, C., and Bell, L. (2001) Learning for inter-professional and interagency practice in the new social work curriculum: evidence from earlier research study. *Journal of Inter-professional Care*, **15** (2): 153-169.

Whittlemore, R., Chase, S., K., and Mandle, C.L. (2001) Validity in Qualitative Research, *Qualitative Health Research*, **11** (4): 522-537.

Willig, C. (2000) *Introducing qualitative research in psychology, adventures in theory and method*, Basingstoke: Open University.

Witz, A. (1992) *Professions and patriarchy*, London: Routledge.

# Appendices

### **Example of reflexivity**

#### **Reflexive notes 1. A caring professional is female**

The image of a hand-maiden often used by the practitioners has strong gender overtones- implying a nurse or a care worker is female.

I have paid little attention to gender and how gender may have impacted upon responses. In some ways I was so used to working amongst women that it was only when Peter remarked about female stereotypes that it drew my attention to this issue.

Was Peter making a statement about his own gender? Did he feel his position undermined because he was a man in a predominately female occupation?

Did he think that I held stereotyped views over occupation and gender?

How did his gender affect his relationships with, the patients other professions and with his peers? Did other practitioners talk to him or relate to him differently (I was not given the impression that they did)?

The comment about silly women and their hats suggests that the uniform would not be important to Peter only that it held nurses back from being a progressive profession.

The comment passed quickly and flowed into something else so I did not pursue this further with Peter and he did not elaborate further.

Likewise it was possible David's difficulty with working with an elderly client was because of his gender. Although his comments suggest it was more that he was part of social services that created the problems.

Because I was female white and a similar age to a lot of the care professionals I believed these aspects of myself and how this positioned me in society made it easier in my interviews. I certainly felt at ease, however with some of the interviews this did not seem to be the case. In the first set of interviews I was more at ease with the social work students than the district nurse students. Therefore I assumed this was not to do with my gender, or ethnicity.

## Reflection 2 :Analysis notes concerning the student project

Basically I have analyzed my preliminary data of student interviews in 3 different ways. Superficially scanned last year forming a template, themes generated from the data, examining the scripts individually by hand and then more recently inputting and coding using the NVIVO2 qualitative software. I had just finished with the last script and to my horror the software crashed some how corrupted the project data [perhaps prophetic my analysis and interpretation corrupted?!]. I am now thinking this may have been a blessing in disguise. I have felt for a while that I was missing 'something' and although I was utilizing an interpretative phenomenological approach, without realizing it I was still taking a very systematic approach to the analysis. Following the crash – I was wondering what I could do to make up for lost time, loss of some codes and coding [some were and some not recorded elsewhere]. I felt a few days rest was in order.

Attending the BPS social psychology conference last week as a steward helped to put this dilemma to one side. I was also able to sit in on a few phenomenological presentations, which I believe is helping me to make connections with my studies. The following are some ideas and points, which the events over the last week have raised for me. The 'crash' I suppose has caused me to stop and reflect on what I was doing – by habit I wanted to rush in and tick off yet another part or stage of the PhD done.

### 1. Narrow or constrained thinking

I feel the danger perhaps I was falling into that the ideas of Professional identity is so entrenched in our culture and thinking -that I was beginning to see the data in terms of a trait or functionalist approach with perhaps a few little associated meanings attached or anecdotes.

### 2. Danger of losing the depth and meaning

[interpreting the data to death] I liked the descriptions from some of the BPS presentations which gave the data life and colour- and although Husserlian 'back to things themselves' nevertheless, the way they described the experiences of their participants - were quite interpretative, as they attempted to empathise with the person to get beneath the dialogue- so to speak. Is it possible to achieve this and how do I present this?

### 3. Personal revelation/inspiration

Finally, an insight or connection that most impacted me was a paper presented by an environmental psychologist. '*Social identity and the reconstruction of space*'. Looking at the impact of a mining community who had to move to a new housing estate. In fact it was the award-winning thesis. Everything about it was fascinating of course but more so the link between social identity and space. I felt this is what was the missing element in my work and unlike the presenter I could make the theoretical connection with Merleau Ponty and the notions of embodiment [I need to re read this again]

### Application to professionals and professional identity

I hadn't quite viewed it this way before but nurses have a recognised space and domain, which is very much visible not only in their symbols tools and actions, but in the space they occupy, which is an extension of them being a nurse or an extension of their professional identity. They have a recognisable territory; the ward, the clinic, the hospital, the GP Practice. The community nurses have more of a struggle in this as it includes in going into peoples homes where they do not occupy the territory so directly. This is more evident in the second set of data I have collected from district nurse focus groups. For example one patient asked a district nurse why she didn't get a proper nurses job in the hospital. Another group of interviews is where the district nurses are so upset at being moved from their base to a temporary hospital base until they were properly relocated. The sharing of space created further hostilities rather than collaboration between the hospital and community nurses. For the nurse her space is very important and enables her to carry out her role and it appears they were more upset at the changes in their space then the changes in their role. { of course I will have to examine this with careful scrutiny}. Likewise joint working and collaborative working means the district nurse has to share her space which may be a part of her identity – some will not wish to do this.

In comparison are the social workers and the students who do not have the same obvious link to a territory or a concrete domain- although they have their working office they do not seem to be confined or restricted by space. Their tools and skills are not visible. They do not do things to people but are advocates look at values and judgements so the students tell me. They see themselves as the silent worker no one knows they are there until things go wrong or if they are obstructing. The public image is low and their good works go unreported. A nurse stated she had a good social worker because he was able to get a move on and coordinate the care- the action was seen. The nurses were quite keen having a social worker on location. Social worker students saw that others view them as 'bottom of the pile' or 'in the way'. They may not be constrained by space but are restrained and even disempowered by legislation. [ I said earlier they did not seem to have a space but perhaps the bottom of the pile is their space- interestingly they do not seem to be unhappy about this place only when it comes to negotiating with other professionals] Perhaps the views they see others have about themselves are similar to the views that others have concerning the clientele they work with. Therefore they can draw along side and can empathise.

For social workers the dilemma is whether to professionalise as this can further separate them from their client but yet gain acceptance and recognition from other professionals. The other dilemma for the social worker is when the client views them as the extension of the system enforcing legislation- like having to take away their children.

From the scripts the social workers do not have the same hang ups about joint-working. Interdependency is apart of their working values however their concerns are related to equity in decision making, both for themselves and their client and the danger of health workers of taking over hence some of them are not too keen of being based in the same place as health workers. So in one sense they have refuge and security in an unseen place they don't have the image or the expectations that the nurses have to live up to.

**All this leads to two main questions**

**1. How do I get the most out of analysis?**

I have very briefly summarised my feelings that come from the scripts rather than systematically using a template- although the ideas generated from the template can be incorporated and give evidence. I feel summarising adds more of a dimension to the work- what do you think? I would like to carry on in a similar vein and use the template more for a sensible way of presenting the information. The only thing about the template or IPA for that matter it separates the flow into discrete paragraphs and entities. Rather than say, what the person or group is trying to tell me? What are the issues for him/her or them? What else is happening and what other links can I make?

I would be interested in your thoughts on this – as to whether I have completely gone 'way off'

**2. What do you think of the connection between space/domain and professional identity?**

Admittedly I feel quite excited about this I have been concerned at whether my work does fall into the category of a PhD on the grounds of either adding or gaining new knowledge. Although this connection is not new in one sense yet I haven't so far come across this connection with social identity or professional identity in any of the organisational or health and welfare literature. The space aspect would nicely fit in with the Hargreaves method as the practitioners identify space in their interactions. Obviously this is not the emphasis of the whole thesis – identifying whether there is space but rather as a finding emerged from the data which is further clarified in the third set of data. In one sense I wished i had came across this earlier as I would have based my phd on this. From my own personal experience I have seen discontent with staff being relocated to new wards or hospitals and nice new units. {Sorry i digress}

Finally, *could I include my thoughts I have expressed with you as part of a reflexive element within the work?*

I hope you have managed to stay with me till the end of this note. I have found it helpful rambling on even if it is to bring ideas together.

**Primary Care Research Group, Ramsden Building, Queensgate,  
University of Huddersfield. Huddersfield.  
Tel: 01484 473611 or Mobile: 07951388241  
Home Base: 01422 300650**

**2nd May 2002**

Dear

Following our telephone conversation of 2<sup>nd</sup> May 2002, I asked if it was possible to interview some of your social workers in relation to a thesis I am writing concerning, **Professional identities relationships and interdisciplinary working**. It was agreed I should write a brief letter of introduction outlining what the interviews would involve.

The research takes a qualitative form of focus groups and individually interviewing Social Workers and District Nurses who have been involved in some form of interdisciplinary working; preferably across the home care interface. The principle aim being is to explore individual and group concepts concerning their roles, professional relationships and how they negotiate these in joint working situations.

It is hoped that may be one or two of your Social Care Assessors or Practitioners (preferably those who hold a social worker qualification) would be interested in being interviewed individually, using a graphic tool I have devised to help in describing professional relationships. Up to date all participants have found this tool a helpful exercise in reflecting upon and tackling challenging situations. The interview will last approximately an hour each and will be anonymised; including the locations of practice. In addition the participant will be informed how the information will be used and can opt out at any stage of the process. I understand that a Social Worker's time is very valuable and it may be difficult to find a convenient time. If it is preferable I could visit during a lunch hour and provide a light lunch.

Do not hesitate to contact me if there are any further queries. Please complete and send the enclosed form or contact me at the above home base.

I look forward to hearing from you.

Yours Sincerely,

**Primary Research Group, Ramsden Building Queensgate campus,  
University of Huddersfield. Direct Tel: 01484 473611**

Address

Dear

I contacted you on Friday 2<sup>nd</sup> March 2001 concerning the possibility of interviewing district nurses within your locality. It was agreed I should write a letter of introduction, informing you of my current status and project details.

At present I am a Ph.D. student working within the Primary Care Research group at University of Huddersfield, and have been involved with evaluating collaborative district nursing services in XXXX and XXX. These evaluations have formed the basis of my studies into **Professional identities, relationships and interdisciplinary working**; with particular reference to District nurses and Social workers. These are currently supervised by Dr Nigel King, Reader (Psychology) and the Director of Primary Care Research Group, Huddersfield. Ms. Janet Firth, Senior lecturer and Head of Community ad Health, Huddersfield. Dr Phil Salmon. (Psychology), London.

Recently, funding has been given by the NHS Contract Research Development Fund so I am able to extend the research into other areas where joint working projects are known to be more established. Therefore, if it is possible I would like to include XXXX within the studies.

The research takes a qualitative form of focus groups and interviews of 5 individuals from each of the two professional groups; being social workers and district nurses. The principle aim being to explore individual and group concepts concerning their roles, professional relationships and how they negotiate these in joint working situations. The individual interviews have utilised a graphic tool to describe working relationships; which up to date all participants have found a particular useful exercise in reflecting upon and resolving challenging situations. Consequently, it is hoped the findings from the study will provide the following outcomes:-

- Inter-professional education and practice with a theoretical basis
- Development and application of interview technique and analysis within an occupational context
- Provide an effective tool for evaluation and reflective practice
- Dissemination of findings through workshops and seminars. Professional and academic publications are expected as well as presentations at relevant conferences.

I would appreciate if you would consider whether your district nursing teams would like to be involved within the study. If you require any further information or wish for me to arrange a visit to discuss this further, please do not hesitate to contact me on: Tel 01484 473611

Yours sincerely,

Angie Ross. B.Sc. (Pyschol) RGN RM.

**Ethics Application form:**

**1. Title of project:** Evaluation of the Out of Hours Service

Location: (Spilsdale) Community Districts  
[Upper, Lower and Central valleys]

Duration: 1 Year

Source funding: XXXX NHS Trust and University of Huddersfield

**2. Workers:**

Responsible Investigator:	Position	Function	Qualification	Pay
Ms. Janet Firth:	Principle Lecturer	Project Leader	RN, DN Cert DNT, DipN M.Ed	N/A
Dr Nigel King	Reader Psychology	Supervise Methodology and phase 1	Phd (Psych)	N/A
Angela Ross	Research student	Collecting	RGN, RM Analysing BSC(hons) Data	N/A Psych.

3. N/A

**4. Objectives of Study**

1. To underpin the development of the Out of Hours Service
2. To explore professional roles and inter-professional relationships during the period of re-organization of the service.
3. To evaluate patient and carer satisfaction of the service
4. To evaluate success in achieving admission avoidance and early discharge.

**5. Scientific background**

The Out of Hours Service is currently being developed by xxxxx NHS Trust. This service is in response to changes in government policies (DOH 1997), the winter pressure initiatives and the need of long term preparations towards future hospital bed closures. These developments will involve reorganisation of local community services which may have implications on professional roles and relationships (Biggs 1997). The new service aims to prevent unnecessary hospital admissions and provide clinical support in the home where necessary. The evaluation aims to underpin these developments by providing information for effective decision and policy-making.

**6. Statistical advice**

- a. Yes. Dr Nigel King University of Huddersfield.
- b. Yes as above

**7. Design of study**

3part project

**Part 1. Group interviews with representatives of staff groups involved and affected by the service.**

Follow-up interview at the end of the year.

**Part 2: Individual interviews with Patient and carers who have used the service.**

Interviews will be taped and analysed by Template Analysis (developed by Dr King). Followed by development of a short questionnaire

**Part3: Admission avoidance and early discharge:**

- i, data on admissions and length of stay of selected groups compared with previous year.
- ii, Case history of patients using the service assessed by Independent panel of health practitioners- in terms of likelihood of admission avoided and appropriateness of out of hours support.

**8. Recruitment**

<b>number</b>	<b>pts/staff inclusion</b>	<b>Exclusion</b>	<b>Pay</b>
---------------	----------------------------	------------------	------------

All users from March 2000	AandE G.P Service Managers	Those who have used the service	}N/A
---------------------------	----------------------------	---------------------------------	------

**9. Risk Assessment**

**Details**  
 Q. Yet to be developed from interviews

**Stress**  
 -----

**Potential benefits**  
 User satisfaction and evaluation of the service

I. Semi-structured:  
 -exploring the advantages  
 - disadvantages of the service  
 the

Will take place at the convenience of the participants

-Encourage user participation in the service.  
 -Ensure quality and satisfaction of service.  
 N/A

OP. N/a

N/A

**10. Confidentiality**

Information will be recorded anonymously with consent- using codes only known to the researcher. Tapes will only be listened to by the researcher and erased following reports.

11.

**12. Patient information:**

Every patient and carer will be contacted by the district nurse and given the enclosed information sheet. The patient and carer will contact the district nurse or researcher if they wish to volunteer.

**Primary Care Research Group**

**University of Huddersfield**

**Potential Participants Contact Form**

**Base/  
Convenient**

<b>Name(s)</b>	<b>Job Title</b>	<b>Telephone Number</b>	<b>Contact times</b>	<b>[Notes: official use]</b>
<b>1.</b>				
<b>2.</b>				
<b>3.</b>				
<b>4.</b>				

**Thank you for your help**

Please return in the Pre-paid envelope to the Primary Care Research Group University of Huddersfield.

## **Developing Interview/Focus groups.**

### **Research objectives:**

1. To explore the ways health and social service professionals construe their identity in the context of collaborative working.
2. To examine specifically the above in relation to the District nursing Out of Hours Service.  
\*impact of these developments on the way the professionals construe their roles/identity and collaborative working

Similar interview questions were used for both Social services and District nurses. Interviews are semi-structured. Therefore the list below are largely prompts to initiate discussion and not necessarily in the order given. Often the participant naturally flows into answering several of the questions before being asked. The How's and why's will be incorporated to probe their constructions more deeply.

### **District Nurse /Social service**

#### **Schedule:**

Preamble: Who I am and what doing

Purpose of the interview : Discussion on the topics : Interested from your perspective what your role is as a district nurse: what the developments within the dn. service mean to you also your feelings on joint working projects

Taping : anonymity

#### **Background Information:**

##### **Roles/Identity:**

Could we start by telling me How would you describe the role of a district nurse ?

*[whether to ask what are the positive and negative aspects to their job] What does your job entail?*

what service do you provide now?

How do you think others see you: *not sure whether to include this although could be interesting response]*

*Has anyone have any different thoughts on this*

##### **Change/developments:**

###### **What changes do you understand are happening?**

How did you first hear of the changes to the service/how and when contacted

*[what would be the ideal and the opposite to that]*

How did you feel about the changes to the service?

*[Do you have any concerns?]*

*[What stands out for you as a district nurse/social worker]*

**How would that affect you?**

*Anymore thoughts?*

**Did you provide cover?**

##### **Criteria/access**

Would you have access to the service?

What is the criteria for the service- has this since changed?

How do you access the service?

How does this provide a better a service?

Why?

Can you identify any positive aspects of the new service: why ?

can you identify any negative aspects of the new service why:?

##### **How would that affect you and the service you provide?**

Have these developments changed or affected your job role? How and in what way?

Any other aspects altered as a result?

What do you think are the advantages of remaining the same?

What are the disadvantages of these changes/developments?

**Future**

Do you see your job changing in the future [how?] and how do you feel about that?  
why?

[what are the advantages / what are the disadvantages or the opposite]

In your view how would you like to see the developments of the service?  
what would be most helpful/ most unhelpful?

**Relationships with others**

What relationships do you have with the other services in particular with the SS

How often do you meet?

What other services do you work with in the context of your daily work? - what about social services? How do you work with each other?

How do you see their role? or what do you think their job entails?

How do you think they see your job role?

Have these developments affected your relationships with other professional each other? [how why]

**Joint working**

what does joint working/collaborative mean to you ?

what do you think JW means to the other professionals you work with?

- From your experience what are the disadvantages of JW and what are the advantages of remaining the same ?
- Do you have any concerns?

How do you see the future in terms of relationships with other professionals?

**Concluding comments**

Anything else you would like to mention

Thank you.

NB. How many and who attended? Grades Cover and No cover

## Social Services : Focus Group

### Schedule:

Preamble: Who I am and what doing  
purpose of the interview  
Taping : animosity

### Background Information:

Can we start by giving me a little background from your perspective about the social services in Calderdale? What does the team consist of?

Your particular job role?

[? whether to ask what are the positive and negative aspects to their job] What does your job entail?

what service do you provide now? [How do other professional see you: not sure whether to include this although could be interesting response]

### Change/developments:

What changes do you understand are happening?

Would that have an affect on what you do

What you do you provide?

How would that affect you and the service you provide?

How did you first hear of the changes to the service/how and when contacted

[what would be the ideal and the opposite to that]

How did you feel about the changes to the service?

[What stands out for you as social worker]

How would that affect you?

Would you have access to the service?

What is the criteria for the service- has this since been amended?

How do you access the service?

How does this provide a better a service?

Why?

Can you identify any positive aspects of the new service: why ?

can you identify any negative aspects of the new service why:?

Have these developments changed or affected your job role? How and in what way?

Any other aspects altered as a result?

What do you think are the advantages of remaining the same?

What are the disadvantages of these changes/developments?

### **Future?**

How do you see your job changing in the future and how do you feel about that?

why?

[what are the advantages / what are the disadvantages or the opposite]

In your view how would you like to see the developments of the service?

what would be most helpful/ most unhelpful?

### **Relationships with others**

What relationships do you have with the other services in particular with the Dns?

How often do you meet?

What other services do you work with in the context of your daily work? - what about social services? How do you work with each other?

How do you see their role? or what do you think their job entails?

Have these developments affected your relationships with other professional each other? [how why]

### Joint working

what does joint working/collaborative mean to you ?

what do you think JW means to the other professionals you work with?

- From your experience what are the disadvantages of JW and what are the advantages of remaining the same ?

What do you think gets in the way of working more together cross agency?

How do you see the future in terms of relationships with other professionals?

**Concluding comments:** Anything else you would like to mention Thank you.

## **Focus group participants**

**1<sup>st</sup> stage April 2000 Day district nurses**

**Details of Focus group 1: Held in Dyer Place Wigglesworth**

<u>Name</u>	<u>Grade</u>	<u>Practice base</u>
Georgina	District nurse (G)	Upp valley: Honsley
Rachael	Staff nurse (E)	Central: :St Georges
Martina	Staff Nurse (E)	Central: St Georges
Lisa	Staff nurse (E)	Central :Brookvale
Claire	District nurse (G)	Central: Brookvale
Debbie	District nurse (G)	Central: Cobblehill
Maryann	District nurse(G)	Central: Cherry trees Rd

**Day district nurse focus group 2 held in upper valley: Honsley**

<u>Name</u>	<u>Grade</u>	<u>Practice base</u>
Briget	District Nurse (G)	Upp: Rossington Rd
Andrea	District Nurse (G)	Upp: Rossington: Duke Hill
Sadie	State enrolled nurse (C)	Central: St Georges Ave.
Susie	Staff nurse (E)	Upp: Brackenbed Lane

**Day district nurses focus group 3: Held in Mistlethwaite Town.**

<b>Name</b>	<b>Grade</b>	<b>Practice base</b>
<b>Dorrie</b>	<b>HCA</b>	<b>Upp: Rossington</b>
<b>Helen</b>	<b>District nurse (G)</b>	<b>Holroyd Place</b>
<b>Paula</b>	<b>HCA</b>	<b>Duke Hill</b>
<b>Jill</b>	<b>HCA</b>	<b>Central: St Peters House</b>
<b>Betty</b>	<b>District nurse (G)</b>	<b>Rossington</b>

**Focus group 4 Twilight and evening staff Held at Dyer Place, Wigglesworth**

<b>Name</b>	<b>Grade</b>	<b>Practice base</b>
<b>Shirley</b>	<b>District nurse (G)</b>	<b>Central: Dyer Place</b>
<b>Tanya</b>	<b>District nurse (F)</b>	<b>Upp: St Peters House</b>
<b>Shona</b>	<b>District nurse (G)</b>	<b>Central: Dyer place</b>
<b>Amelia</b>	<b>Staff nurse (E)</b>	<b>Lower: Mistlethwaite</b>
<b>Phoebe</b>	<b>HCA</b>	<b>Upp: St Peters House</b>
<b>Stevie</b>	<b>HCA</b>	<b>Central: Dyer Place</b>
<b>Dawn</b>	<b>HCA</b>	<b>Central: Dyer Place</b>
<b>Sybil</b>	<b>HCA</b>	<b>Upp: St Peters House</b>
<b>Lynn</b>	<b>HCA</b>	<b>Upp: St Peters House</b>

**Focus groups with Social care workers-**

**1. Honsley- upper valley team**

<b><u>Name</u></b>	<b><u>Grade</u></b>
<b>Pat</b>	<b>Home care manager</b>
<b>Andrea</b>	<b>Homecare Manager</b>
<b>Rob</b>	<b>Social care assessor Team leader</b>

**2. Central team- Wigglesworth**

<b><u>Name</u></b>	<b><u>Grade</u></b>
<b>Joan</b>	<b>Senior practitioner: Social care assessor</b>
<b>Beattie</b>	<b>Acting Team manager adult team</b>
<b>Tony</b>	<b>Social care assessor</b>
<b>Sheron</b>	<b>Social care assessor</b>
<b>Phil</b>	<b>Social Care co-ordinator</b>
<b>Ange</b>	<b>Social care co-ordinator</b>
<b>Heather</b>	<b>Social care co-ordinator</b>
<b>Lydia</b>	<b>Social care co-ordinator</b>
<b>Diane</b>	<b>Benefits maximisation officer</b>
<b>Hannah</b>	<b>Benefit maximisation Officer</b>
<b>Jo</b>	<b>Social care assessor</b>
<b>Lauren</b>	<b>Social care assessor</b>

**Social care focus group 3. Lower valley team : Mistlethwaite**

<b>Name</b>	<b>Grade</b>
<b>Jane</b>	<b>Social Care Team Manager</b>
<b>Maggie</b>	<b>Social care coordinator</b>
<b>Petra</b>	<b>Social care assessor</b>
<b>Liz</b>	<b>Social care assessor</b>
<b>Corrie</b>	<b>Social care assessor</b>

**Social care focus group 4. South Wigglesworth team**

<b>Name</b>	<b>Grade</b>
<b>Janet</b>	<b>Social care team leader</b>
<b>Paul</b>	<b>Senior practitioner</b>
<b>Monica</b>	<b>Social care assessor</b>
<b>Christine</b>	<b>Social care assessor</b>
<b>Annabel</b>	<b>Social care coordinator</b>

**Stage 2: Follow up focus groups, between January and March 2001**

**Day District nurse focus group 1; held in Mistlethwaite, Lower valley**

<b>Name</b>	<b>Grade</b>	<b>Practice</b>
<b>Kath</b>	<b>District nurse (G)</b>	<b>Lower: Holroyde Rd</b>
<b>Claire</b>	<b>district nurse (H*)</b>	<b>Central: Brookvale</b>
<b>Katie</b>	<b>Student district nurse</b>	<b>Central :Brookvale</b>
<b>Ketura</b>	<b>Staff nurse (E)</b>	<b>Lower: Mistlethwaite</b>
<b>Heather</b>	<b>Staff nurse (E)</b>	<b>Central:St Georges</b>
<b>Peter</b>	<b>District nurse (F)</b>	<b>Central: North tower</b>
<b>Annmarie</b>	<b>Staff Nurse (E)</b>	<b>Central: Dyer Place</b>
<b>Debbie</b>	<b>Districts nurse (F)</b>	<b>Lower; Risley Staple</b>
<b>Diane</b>	<b>Staff nurse (D)</b>	<b>Lower: Risley Staple</b>

**Day district nurse focus group 2; held in Central Wigglesworth**

<b>Name</b>	<b>Grade</b>	<b>Practice base</b>
<b>Linda</b>	<b>District nurse (G)</b>	<b>Central: Gareth Place</b>
<b>Linda</b>	<b>Staff nurse (E)</b>	<b>Central: Gareth Place</b>
<b>John</b>	<b>Student (general ) Nurse</b>	<b>Central: Gareth Place</b>

**Day District nurse focus group 3; held in Honsley – upper valley**

<b>Name</b>	<b>Grade</b>	<b>Practice base</b>
Jeanette	Staff nurse (E)	Central: Duke Hill surgery
Sonya	Staff nurse (E)	Upper Honsley
Trish	HCA	Upper : Honsley
Georgina	District nurse (G)	Upper: Honsley

**Out of hours district nurse focus group 4: held in the Wigglesworth General OPD**

<b>Name</b>	<b>Grade</b>	<b>Practice base</b>
Aileen	District nurse (G)	Support team
Shirley	District nurse (G)	Central base:OPD

**Out of hours District nurse focus group 2: Held in the OPD of the Wigglesworth General**

<b>Name</b>	<b>Grade</b>	<b>Practice base</b>
<b>Shona</b>	<b>District nurse (G)</b>	<b>Central Base :OPD</b>
<b>Bryoni</b>	<b>District nurse (G)</b>	<b>St Georges</b>
<b>Natalie</b>	<b>Staff nurse (E)</b>	<b>Pawson Road</b>
<b>Amelia</b>	<b>Staff nurse (E)</b>	<b>Pawson Rd</b>
<b>Jade</b>	<b>HCA</b>	<b>Pawson Rd</b>
<b>Anne</b>	<b>District nurse (G)</b>	<b>Central Base: OPD</b>
<b>Jacky</b>	<b>HCA</b>	<b>Central Base OPD</b>
<b>Dawn</b>	<b>HCA</b>	<b>St Georges House</b>
<b>Ruth</b>	<b>Staff nurse (E)</b>	<b>St Georges house</b>
<b>Lynn</b>	<b>HCA</b>	<b>St Georges house</b>
<b>Berni</b>	<b>Staff nurse (E)</b>	<b>Central base :OPD</b>
<b>Sonya</b>	<b>HCA</b>	<b>St Georges House</b>

**Follow up focus groups with social care workers**

**Social care focus group 1. Upper valley Honsley Team**

<u>Name</u>	<u>Grade</u>
Pat	Home care manager
Andrea	Home care manager
Rob	Social care assessor: team leader
Debbie	Home care manager :Coordinator of out of hours home care service

**Social care focus group 2. lower valley : Mistlethwaite Team**

<u>Name</u>	<u>Grade</u>
Hiliary	Reviewing officer
Jane	Social care team leader
Maggie	Social Care coordinator
Kitty	Social care coordinator

**Social care focus group 3 South Wigglesworth Team**

<u>Name</u>	<u>Grade</u>
Janet	Social care team leader
Simon	Rehabilitation officer
Monica	Social care reviewing officer <sup>4</sup>
Christine	Social care assessor
Annabel	Social care coordinator

<sup>4</sup> same person change of job

**Social care focus group 4 Central Wigglesworth team:**

<b><u>Name</u></b>	<b><u>Grade</u></b>
<b>Joan</b>	<b>Senior practitioner Team leader</b>
<b>Beatie</b>	<b>Acting team manager adult team</b>
<b>Lisa</b>	<b>Social care coordinator</b>
<b>Julie</b>	<b>Reviewing officer</b>
<b>Heather</b>	<b>Benefits maximisation officer</b>
<b>Diane</b>	<b>Benefits maximisation</b>
<b>David</b>	<b>Social care coordinator</b>
<b>Lauren</b>	<b>Home care manager</b>
<b>Viv</b>	<b>Customer service officer</b>
<b>Sheila</b>	<b>Social care assessor</b>
<b>Janie</b>	<b>Social care assessor</b>
<b>Sheron</b>	<b>Social care assessor</b>

## Appendix Analysis Templates

Table 1 District nurse themes.

Table 2. Social care work themes

- Training
  - Differences between staff
  - Responsibilities and roles
- Communication
  - Lack of contact
  - Isolation
  - Distance between practitioners
- Response to changes and developments
  - i. Concerns :
    - Deskilled – role eroded
    - Service developments good
    - Workload increased
    - Fear of being a dumping ground
    - Changes in roles
  - ii. Benefits
    - Challenged- role extension
- Recognition by others and organisation
  - Forgotten service
  - Unsupported
  - Unmet practitioner needs
  - Patient expectations and perceptions
- Joint working with social services
  - Difference in criteria
  - Differences in care
- Inter-professional Relationships
  - with GP
  - Acute services

- Teams
- Roles and responsibilities
  - Approach to care
  - Structure of service
  - Differences between services
- Recognition by others
  - Not understood by health
  - Lack of consideration
  - Patient and public perceptions
- Response to changes and developments
  - i. Concerns:
    - Health taking the lead:- loss of role
    - Resources: [Not meeting the need]
    - Patient expectations: viewed as unqualified
  - Training
    - The dumping ground
    - Time and Speed of response
  - ii. Benefits of devolment
    - Patient needs
    - Frees the nurse
    - Home care Staff roles extended
- Inter-professional Relationships
  - GP
  - District nurse
  - Working alongside

## **Hargreave's Reflective Layouts**

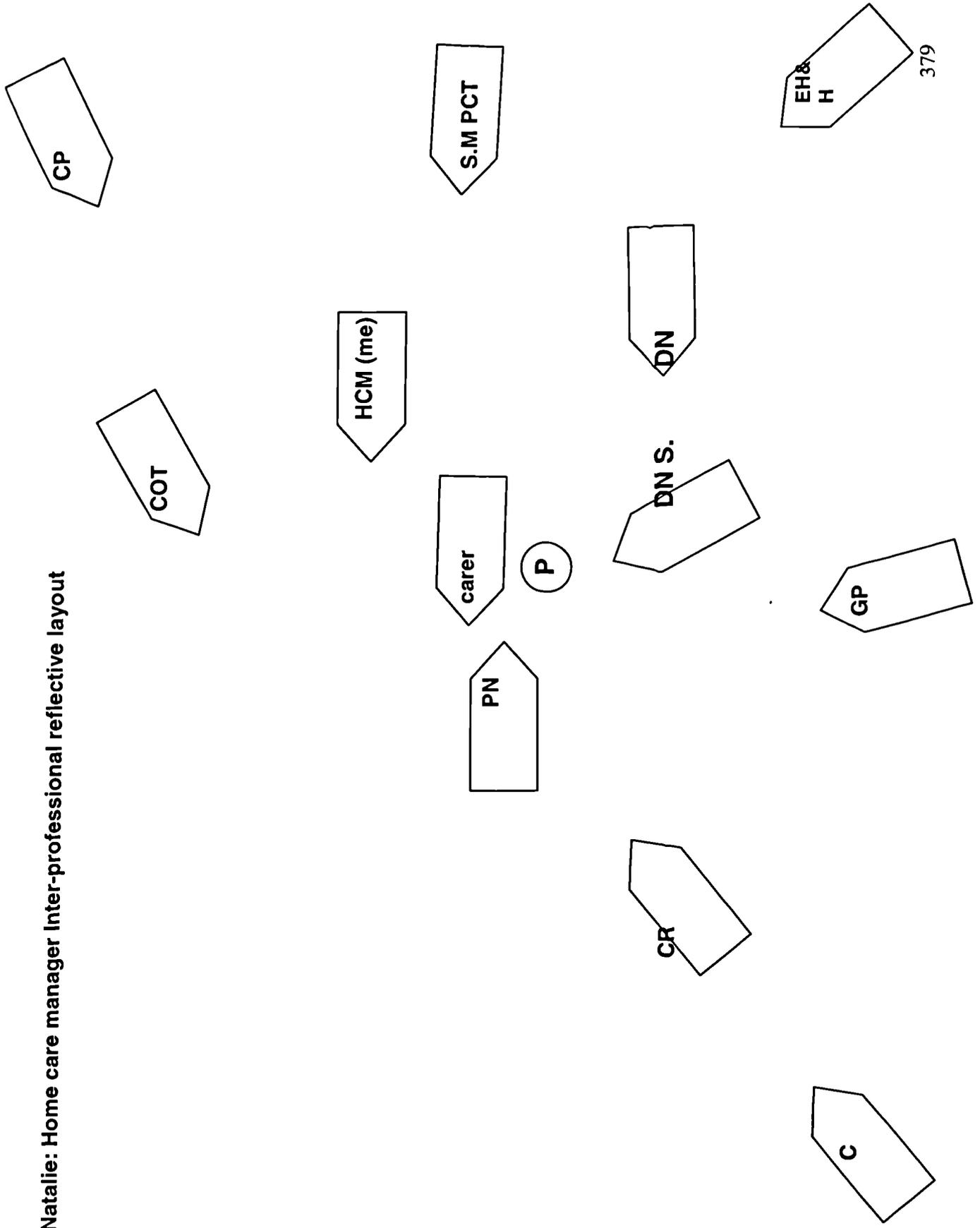
**Natalie: Senior practitioner**

**Debbie: Home care manager**

**Claire: District nurse**

**Wendy: District nurse**

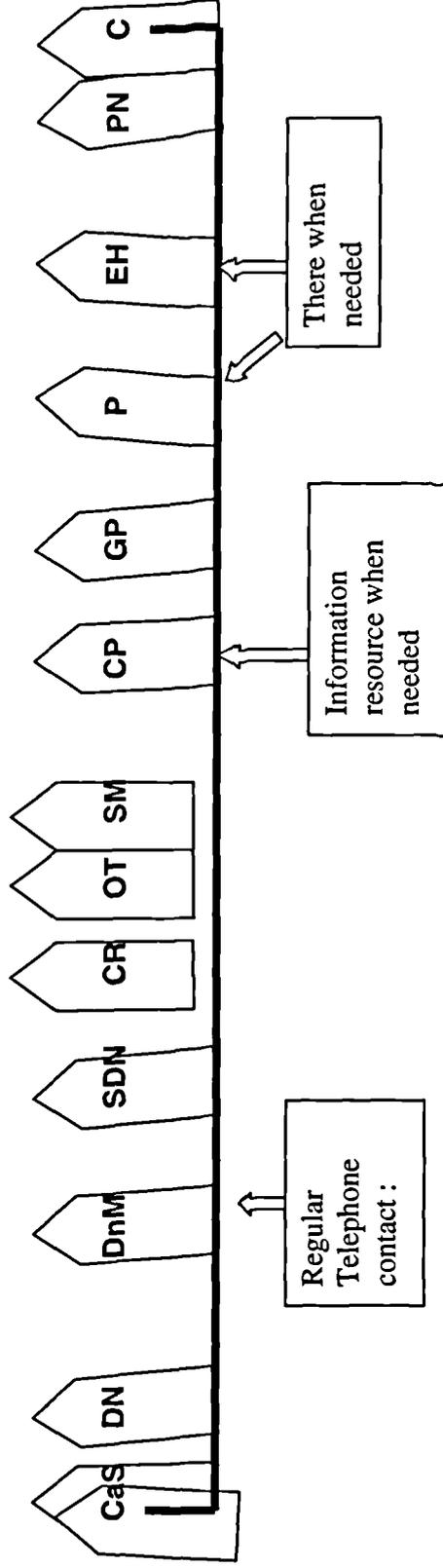
**Natalie: Home care manager Inter-professional reflective layout**



Natalie Salmon Line

Close working relationships

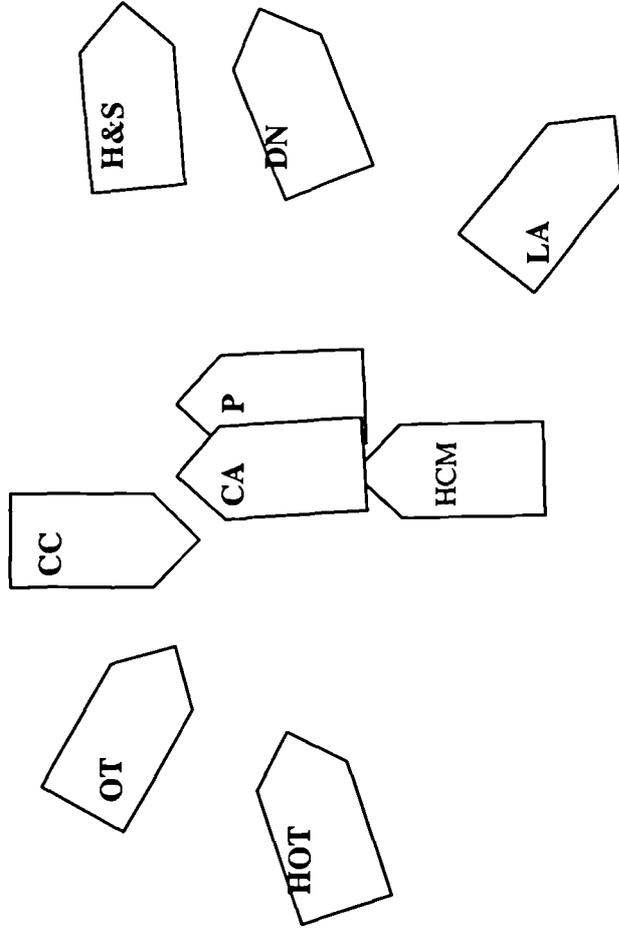
Little contact



**Key:**

**HCM (S):** Home Care Manager **DN:** District nurse **DnM:** District nurse Manager  
**C:** Carer **SDN:** senior District Nurse **CR:** Community Rehab **SM:** Senior Manager (PCT)  
**GP:** General Practitioner **P:** Police **EH:** Environmental Health **PN:** Private Nurse  
**C:** Consultant **CP:** Carers Project **COT:** Community OT **H:** Housing

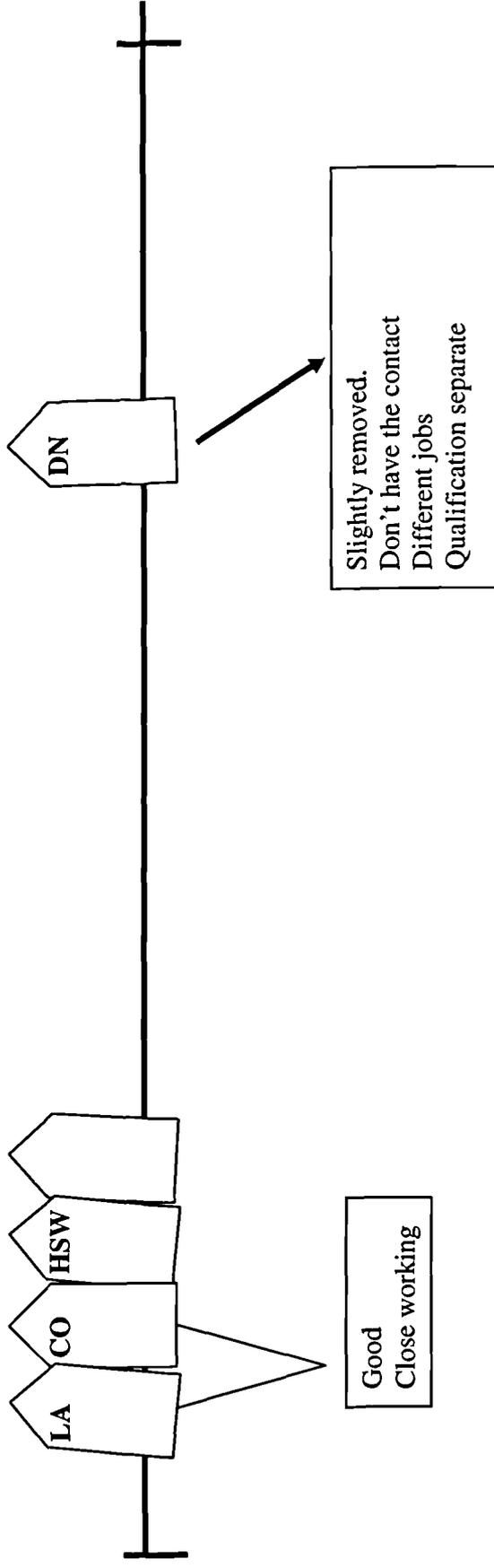
**Debbie: Homecare manager Inter-professional layout**



**Key**  
**CC** : Care coordinator **DN**: District Nurses **HCM**: Home care manager  
**HOT**: Hospital Occupational therapist **H&S**: Health and Safety **LA**: Lead

**Debbie Salmon Line:**  
**Communicates well**

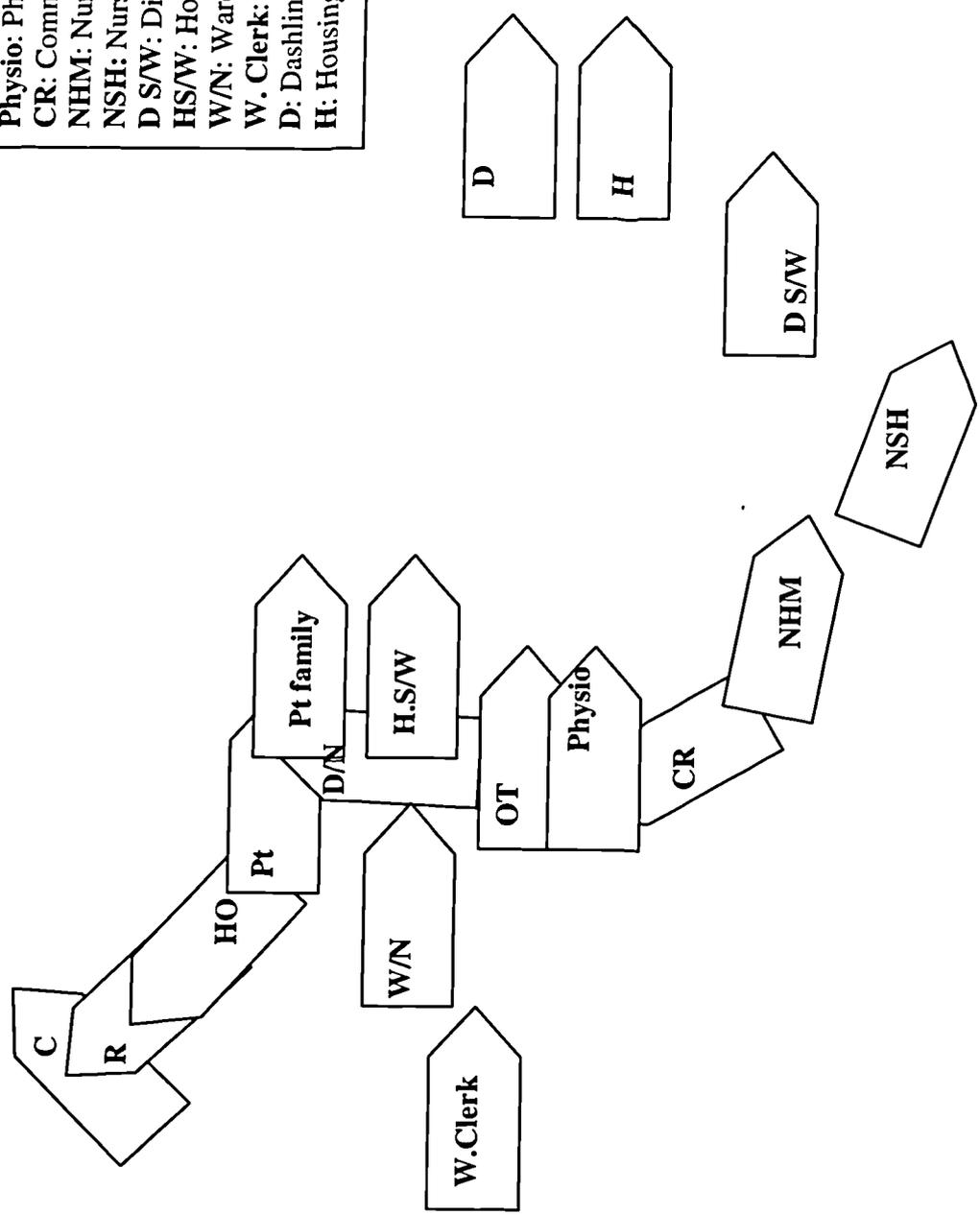
**Poor**



**Claire: District nurse coordinator: Inter-professional Relationships Reflective layout**

**KEY**

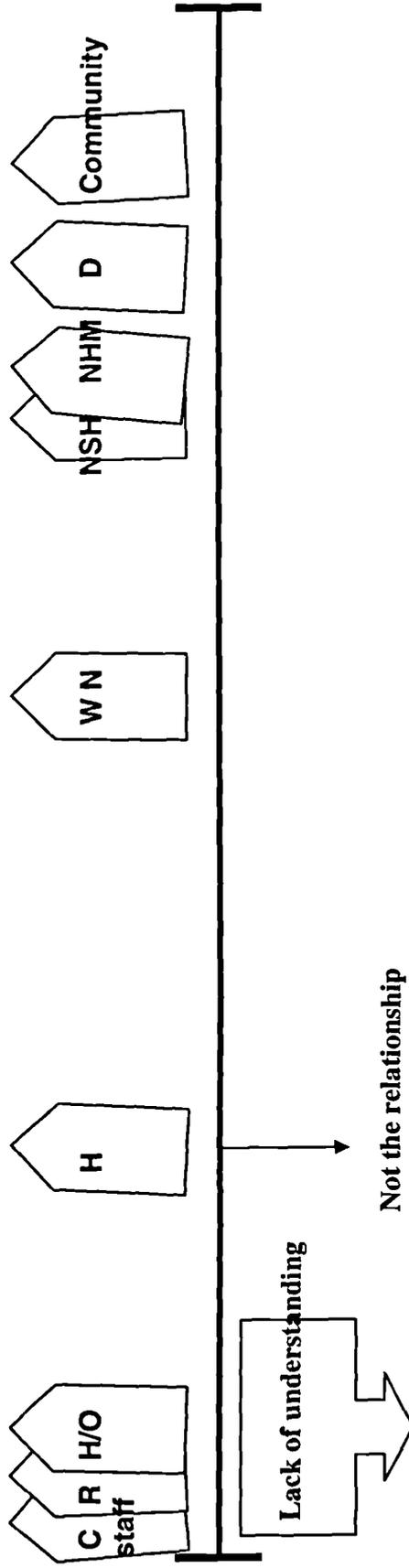
- C: Consultant
- R: Registrar
- HO: House officer
- Pt: Patient
- Pt family: Patient's Family
- D/N: District Nurse Coordinator
- OT: Occupational Therapist
- Physio: Physiotherapist
- CR: Community Rehab Team
- NHM: Nursing Home Manager
- NSH: Nursing Home Staff
- D S/W: District Social Worker
- HS/W: Hospital Social Worker
- W/N: Ward Nurses
- W. Clerk: Ward Clerk
- D: Dashline
- H: Housing Dept



**Salmon Line: Claire**

**Poor joint working  
working well**

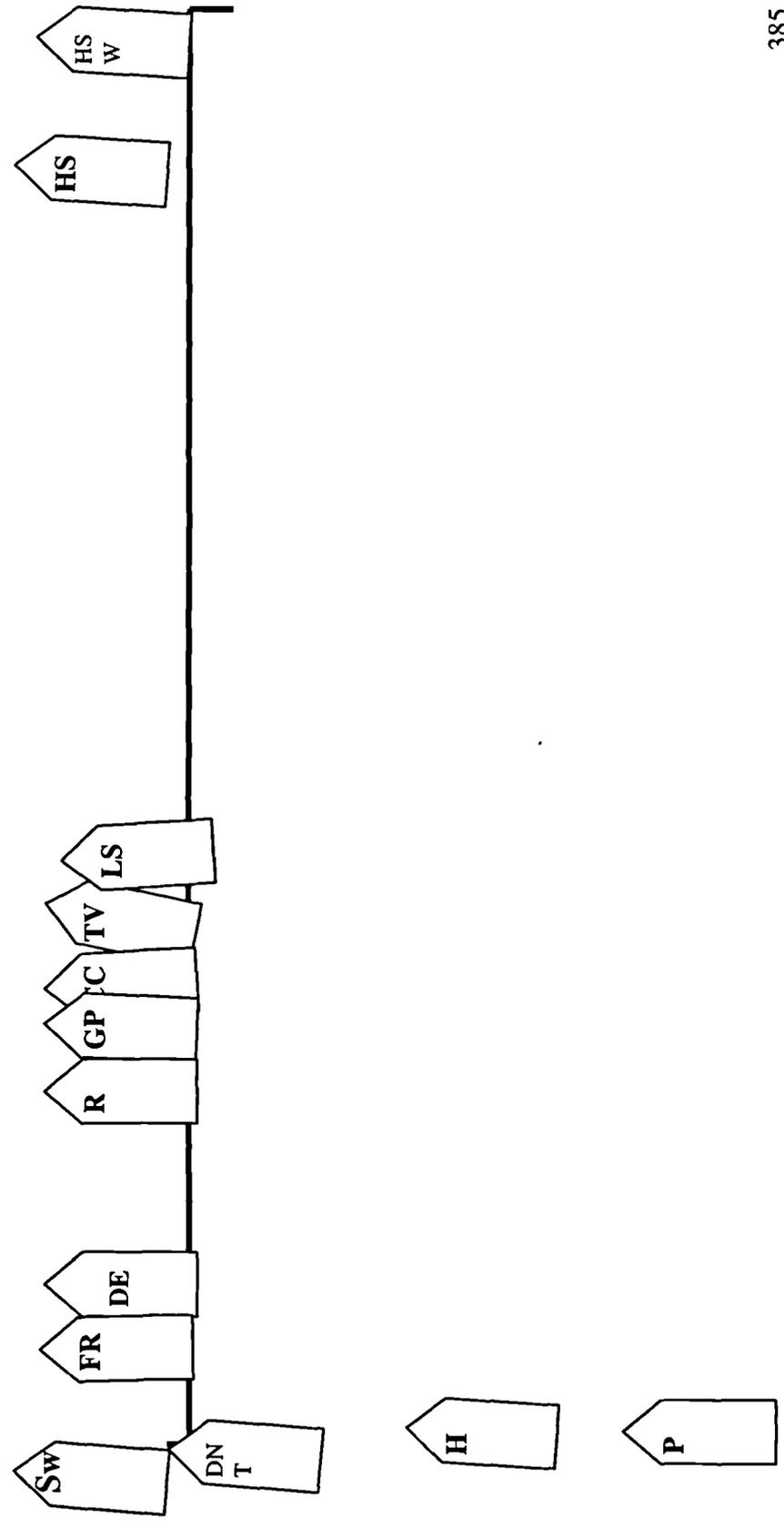
**Joint**

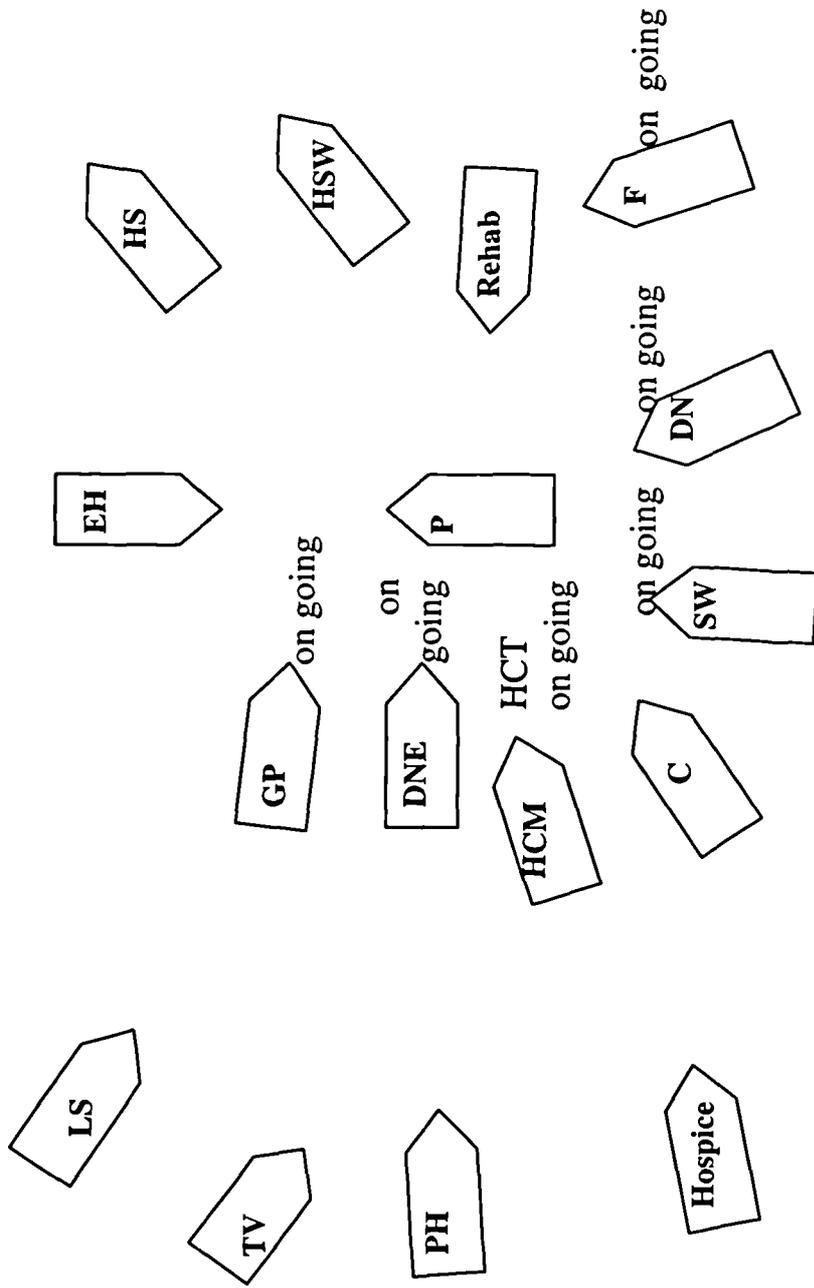


# Wendy district nurse: Salmon Line

Good working relations: negotiation and achieving an outcome

Poor





**Wendy: Interprofessional Layout** **Key:**  
 C: chemist DN: District nurse team DNE: evening district nurses E: Environmental Health  
 F: Friend GP: family doctor HCM: Home care Manager H: Hospice HSW: Hospital social  
 worker HS: hospital staff LS: Loan stores P: Patient PH: Pennine Housing Rehab: