Workforce Matters:
Exploring a New Flexible Role in Health Care

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Declaration

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"Our objective is to liberate the talent and skills of all the workforce so that every patient gets the right care in the right place at the right time"

(Department of Health 2002, p.34)

"I think the interprofessional care co-ordinators are a very good example of the way things operate in that we have lots of ideas, we get these things started, we're really interested in them to start with and then we move on to something else, and we leave these people to sort themselves out and get on with it."

(Manager in interview on interprofessional care co-ordinator role, 07059 Int)

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Abstract

This thesis describes an action research study that took place in the context of increasing intervention by UK central government in the shaping and delivery of health services, and broadening expectations about who could deliver services. The study was aimed at exploring the issues arising from the development of the interprofessional care co-ordinator (IPCC) role in an acute in-patient setting. The role was new, introduced with an inherent flexibility that enabled IPCCs to speed patients through their in-patient stays as fast as clinically possible. None of the four IPCCs appointed held a registrable qualification in health or social care. A review of the literature identified that very little is known about care co-ordinator roles in practice, particularly those held by non-registered workers.

The study reported in this thesis began two years after the IPCCs took up post. The study's objectives were to describe the characteristics, impact, issues and influences on the role. A wide range of qualitative and quantitative data were gathered and analysed between October 1998 and July 2000 within the framework of an action research approach.

The findings identified that the IPCC role had informally shifted over time to take up the complex discharge planning work previously carried out by nurses. This shift was not reflected in Trust policy and had not been accompanied by a review of training, regulation or supervision. This had led to situations of risk for some patients.

The findings threw light on contextual factors that enabled the role shift and disrupted the reflective leadership and long-term overview needed to monitor and respond to the shift. These factors included nursing staff shortages and a turbulent environment for managers characterised by multiple pressures, top-down targets particularly for acute efficiency, and high managerial turnover. In addition, nurses did not perceive that they had an influence on the ongoing development of the IPCC role.

The findings support Abbott's (1988) theory that an occupational group can take up the discarded work of a higher status occupational group, but challenge the theory that the work discarded is always more routine than the work retained. They support theories of a growing challenge to the primacy of professional knowledge and the existence of an organisational culture in the NHS in which there are broader expectations of who can deliver which health services. They also indicate that role substitution can lead to the routinisation and marginalisation of aspects of patient care.

The findings also illustrate how an innovation can continue to be re-invented following its establishment into routine practice, and how the journey of an innovation can be influenced by its context. The findings throw light on a role in practice that is a cameo of current policy on new roles and have a number of implications for practice, policy, education and research.

Abbreviations

AMSPAR	Qualification from Association of Medical Secretaries, Practice Managers, Administrators and Receptionists
BT	British Telecom
Care co-ordinator	Interprofessional care co-ordinator
CWP	Changing Workforce Programme
ECG/EKG	Electrocardiogram
FG	Focus group data
GP	General practitioner
HCSW	Health care support worker
HQS	Health Quality Service
IPCC	Interprofessional care co-ordinator
IPR	Individual performance appraisal
Int	Interview data
MED	Medical and Emergency Directorate
MRSA	Multi-resistant staphylococcus aureus
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NUD*IST	Non-numerical Unstructured Data Indexing Searching and Theorizing
NVQ	National Vocational Qualification
ODA/P	Operating department assistant/practitioner
OT	Occupational therapist/ therapy
PAMs	Professions allied to medicine
PAS	Patient administration system
PCTs	Patient care technicians
Physio	Physiotherapist/ physiotherapy
PMS	Personal medical services
PSR	Professional self-regulation
R&D	Research and development
RGN	Registered general nurse
UK	United Kingdom
US(A)	United States of America
USSs	Unit support specialists

1 Introduction

This thesis describes an action research study that aimed to explore the issues arising from the development of a new flexible role in an acute medical in-patient setting, held by practitioners without a nationally registered qualification in health or social care. The role was that of the interprofessional care co-ordinator (IPCC). The thesis is written as a case study with sufficient contextual depth to prompt the reader to judge for themselves the relevance of the work to their own practice. In addition, the thesis adds to the body of knowledge by developing particular theoretical perspectives.

The study objectives were:

1. To describe the characteristics of the IPCC role

2. To explore the impact of the IPCC role on interprofessional working and patient care

3. To highlight the issues arising from the operationalisation of the IPCC role

4. To identify the key contextual influences that shaped the IPCC role

The Medical and Emergency Directorate (MED) of Barts and The London NHS Trust includes six in-patient acute general medical wards. These wards are known as the general medical service. In 1996 directorate managers introduced the IPCC role. This new role was in response to a recognition that more flexible working could fill gaps in patient care that would not otherwise be filled and that there was scope for the administrative co-ordination of the contributions of different professional groups to the care of individual patients. The four IPCC posts were taken up by individuals who between them had extensive administrative experience in the Trust, but no health or social care qualifications. The IPCCs worked with the 'core' members of the interprofessional team. This membership was determined by frequent attendance at the weekly interprofessional team meetings and included doctors, nurses, social workers, physiotherapists and occupational therapists. As will be illustrated, the IPCCs were originally introduced as an administrative

support worker and it was intended that they should take on work of this kind from all of these core team members.

From an early stage of introducing the IPCC role, directorate managers were keen to evaluate its impact on the service. St Bartholomew School of Nursing and Midwifery at City University were invited to conduct a pilot project to evaluate the new role shortly following its introduction (Reeves et al. 1999a). The results from this pilot study raised a number of issues that managers were interested in examining further. Most data collection was conducted as the new role was being introduced and the issues identified included an uncertainty about what the IPCCs could contribute that was new in relation to existing interprofessional contributions and some early anxieties that the work of the IPCCs could overlap into the territory of existing professional groups.

Following the completion of this pilot study, a successful application was made by directorate managers and City University research staff to the Multidisciplinary Health Service Research Subgroup of the Trust's Research Advisory Committee to carry out a wider study over a two-year period further investigating the role. Part of the Trust's NHS Research and Development (R&D) Levy was used to fund the work and this funding enabled the data collection for the study reported here to take place.

1.1 Local background

Within Barts and The London NHS Trust, MED provides accident and emergency services and acute in-patient hospital care at the Royal London Hospital for adult non-surgical patients. MED includes a specialist and a general medical service. The local population is ethnically diverse and the borough is widely recognised to have high levels of deprivation.

The vast majority of patients to the general medical service are emergency admissions either referred from general practitioners or from the accident and emergency department. The defining characteristic of the general medical service is that the referred patient does not have a diagnosis sufficient to route them to one of the more specialist medical departments, or alternatively the referring doctor does not wish the patient to go to that more specialist service, at least in the first instance. The general medical service runs six in-patient general medical wards

(totalling 153 beds) although may often have patients outlying from these as well. Patients are usually admitted for up to 48 hours onto the emergency admissions ward and, should further in-patient stay be required, they are then transferred to one of the other five wards or another ward if there are no free beds on general medical wards. Although there is a separate system for admitting older patients, the care of the elderly service is limited by the number of beds available and so many older patients are cared for within the directorate.

For the year April 1997-March 1998, the general medical service admitted 6,466 patients (an average of 18 patients per day), 52.8% of whom where aged 60 years or more. Twenty consultants contribute to the service (eight at any one time), and all of these consultants have specialist interests in addition to their participation in the acute general service. Prior to this study, while some attempts were made to 'ward-base' the consultants, the nature of the admissions procedures and the pressures on the service meant that, in practice, a consultant might have patients in beds on any of the six wards.

Local changes cited by MED managers that preceded the introduction of the IPCCs in 1996 included:

- The local impact of the nationwide increase in emergency admissions
- A recognition that discharges were often delayed beyond clinical fitness for discharge
- The need for reduced length of stay because of financial constraints
- The need for better community links and services both before admission and after discharge
- The need to improve collaboration between health and social services
- Strong pressure from the Department of Health and from professional organisations to produce and follow guidelines of management for specific conditions
- A narrowing of duties expected to be undertaken by trainee doctors
- A reduction in hours of work for trainee doctors
- An increased patient expectation of what will be achieved in a short space of time and also how they will be informed about their care.

To address these problems, particularly those of delayed discharges, and to provide roles that focused on the largely administrative co-ordination of care within the general medical service, the directorate appointed three IPCCs from administrative

personnel within the hospital. These IPCCs took up their posts in September 1996. The number of IPCCs was expanded to four in April 1999.

The four IPCCs had all worked in largely administrative roles in the Trust prior to taking up the IPCC role. Two IPCCs worked as a ward clerk, one as an administrator for diagnostic imaging, and one as a (nursing) health care support worker. One of the two IPCCs who had worked as a ward clerk had also worked as a bereavement and convalescence officer. None of the IPCCs held any health or social care qualifications, with the exception of the IPCC who had previously worked as a health care support worker. As part of this role, she had achieved Level 3 National Vocational Qualifications (NVQs) in acute care and clinic and outpatient care. When the IPCC role was first introduced, the senior nurse took the IPCCs through an induction that involved their close supervision in practice until competency was judged by the senior nurse to have been reached. Any new IPCCs joining since that time were inducted by their IPCC colleagues, mostly by shadowing them in practice. No other ongoing formal training was provided.

The IPCCs' first manager was the directorate's senior nurse. After a few months, their management was taken over by the directorate's two operations managers (who job-shared the operations manager role). The operations manager post was more senior than the senior nurse post and the change in management was an opportunity for more senior involvement with the operational issues the IPCC role was raising. The operations managers were responsible for the general management of the MED directorate and tackled many of the daily operational issues that cropped up. Together with the MED clinical director, they were also involved in longer term strategic planning for the directorate.

All four IPCCs were women aged (in 1998 at the start of this study) between 41 and 53 years. Their pay as IPCCs was equivalent to that of a nursing E grade, that is a senior staff nurse[1].

1.2   Phases of the study

This section will set out the order of events in the action research study in order that each event can be understood in the context of a wider story. The order of events is summarised in Figure 1.1. This structure was applied in retrospect rather

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[1] Around £15,000 *per annum* in 1999.

than in advance of the study, as the focus of the inquiry changed in the light of emerging findings, developments and events external to the study. This dynamic approach to study design is common in action research. Data collection and development work are adapted as events unfold in the reality of practice, and as emerging findings are fed directly into practice. It is therefore not usually possible to predict the course that an action research study will take. While in reality, different aspects of the study were not as clear-cut as Figure 1.1 indicates, the framework illustrated has been adopted for ease of explanation. The study took place between October 1998 and July 2000.

1.2.1   *Early days*

The study began in October 1998 with my entry into the Trust and the establishment of the study. Prior to this, an ethical code of practice for the study had been agreed with the local research ethics committee. I came to the post of lead investigator of this study with an expertise in the nursing care of acutely ill older people and the experience of working as lead investigator on a previous action research study in acute care (Meyer & Bridges 1998). I had a Masters degree in nursing with a specialisation in acute care gerontology and, prior to this study commencing, had worked for six years in a range of practice development and organisational development posts. This work had initially been solely in nursing but had broadened out to incorporate other members of the interprofessional team and managers. Through this work I had developed a strong belief that successful developments in patient care were dependent on the active participation and direction of practitioners, and on the commitment and participation of more senior personnel in organisations.

Following my induction, a steering group for the study was assembled with representation from the IPCCs, directorate managers and representatives of the key staff groups working alongside the IPCCs. This group met monthly for the first 12 months of the study and took on the function of being the main forum in which study findings were shared and in which decisions were made about next steps in data collection and development work. In addition to establishing the steering group, my early time at the Trust was also spent in developing relationships with the IPCCs, their managers and interprofessional colleagues, and exploring their expectations and desires for the study.

All individuals involved at this early stage were happy to be involved in the study, although it was clear that the main initiative for the study had come from the directorate's clinical director, senior nurse and two operations managers. These individuals were very welcoming to me, and willing from an early stage to commit time and resources to the study. They were all clearly well established in their roles, well liked and respected by other directorate staff, and regarded more widely in the Trust as innovative in their thinking and as a successful management team. The senior nurse had decided to leave the Trust to seek wider experiences and was actively looking for a new job as I began the study. This individual left the Trust in December 1998 and was replaced by one of the ward managers already working in the directorate.

Figure 1.1   Phases of the study

Project phases	Oct 1998		July 2000
	Exploration	**Action**	**Reflection**
Focus of data collection	Data collection around defining the role and issues→→→→→→→		Reflection on processes and outcomes, and planning for future change
		Data collection around process and outcomes of change→→→→→→→→→→→→→→→→→→→→→→	
Focus of development work		Action research cycle 1: Communicating about the IPCC role→→→→→→→	
		Action research cycle 2: Exploring issues of accountability→→	
		Action research cycle 3: Improving interprofessional working→→→→→→→	
Involvement of participants in study direction	Steering Group→→→	Interprofessional development workshops	
	Meetings with key participants→→→→→→→→→→→→→→→→→→→→→→→→→→→		

A description of the three main study phases now follows.

1.2.2   Exploration phase

It became clear at an early stage that, although the IPCC role had been established for two years, uncertainty remained among their interprofessional colleagues about what the IPCCs actually did. These preliminary findings prompted the establishment of an exploration phase of data collection, during which the focus of inquiry was on describing the characteristics of the IPCC role, describing its impact on patient care and interprofessional working and identifying the issues arising from the operationalisation of the IPCC role. This phase was the first of three phases of data collection and began in November 1998.

At this time, the Trust board announced a restructuring of management arrangements across the Trust to take effect from October 1999. The board proposed a reconfiguration of which services were managed together. For the general medical service, this involved being managed with the accident and emergency department and the specialist medical wards (it had previously been managed separately). It was proposed that the operations manager posts were eliminated, and each of the larger directorates were run by a directorate board comprising a clinical director, a general manager, a head of nursing, a financial manager, a human resources manager and an administrative manager. The senior nurse post for general medicine (rather than the wider directorate) was to remain. This announcement caused a great deal of anxiety and uncertainty among the individuals whose jobs were at risk. Operations managers across the Trust organised a collective response to the board's proposals and succeeded in persuading the board to lengthen the time allocated for the period of transition from April 1999 to October 1999. Directorate staff were unsure about the virtue of disrupting what was seen to be a successful management team, and uncertain about what the future would bring.

The proposed restructuring prompted the departure from the Trust of the two operations managers in June 1999. The operations managers had managed the IPCCs prior to their departure and the elimination of their post led to a period of uncertainty about who would best manage the IPCCs in the new structure. This role was finally taken on by the senior nurse for general medicine. However, the IPCCs continued to be seen as a resource to the interprofessional team as a whole and not under the direct remit of any one professional group.

As part of the wider Trust restructuring, the clinical director for general medicine became the clinical director for the new larger directorate. This appointment provided a much needed continuity for the study.

1.2.3 Action phase

Having described the characteristics of the IPCC role in the exploration phase, a number of issues were raised. Exploring and addressing these issues became the main development work of the action research study and took place as a series of cycles within the study's action phase which began in January 1999. An action research cycle is a process of diagnosing, planning action, taking action and evaluating action (Coghlan & Brannick 2001), and development work within this study took place within the framework of three such cycles: 'communicating about the IPCC role'; 'exploring issues of accountability'; and 'improving interprofessional working'.

As the action phase developed, the steering group that had originally managed the project stopped meeting. The interprofessional workshops that took place within the action research cycles (see below) took on the functions of the steering group meetings and this allowed for wider representation in decision-making about the course of the project.

1.2.3.1 First action research cycle: communicating about the IPCC role

This cycle began in January 1999 and continued through to the close of the study. As noted above, data collected in the exploration phase suggested that there were a number of issues related to communication about the IPCC role. Social workers were unclear about a number of aspects to the role and this, among other issues, had created tensions between the IPCCs and their social work colleagues. Dieticians and speech and language therapists knew very little about the IPCC role despite the fact that there was scope for closer working. A number of accounts were shared of patients who were not clear about the IPCC role. Apparently, patients commonly confused the role with a social work role. Finally, the directorate had been in receipt of a number of enquiries about the IPCC role from other hospitals interested in setting up similar roles. There was, however, no written information about the role apart from the IPCC job description.

A number of approaches were taken in this cycle to address the issues raised. Two joint meetings were convened between directorate staff and social workers to give social workers the opportunity to air their concerns and learn more about the IPCC role and the priorities of the acute hospital sector. A meeting was held with dieticians and one of the IPCCs to explain more about the IPCC role and explore opportunities for joint working. A business card was developed which included IPCC contact details and a brief description of the IPCC role. This was designed to give to patients and families. An article was written for publication about the role, and an information pack was also constructed which captured the lessons learned about implementing the role.

1.2.3.2 Second action research cycle: exploring issues of accountability

This cycle began in November 1999 and continued through to the end of the study. Data from the exploration phase had suggested a number of issues around accountability and the role of the IPCC. Despite the relative autonomy of IPCC working, a contrast was identified between the way that IPCCs work and the frameworks within which their professional counterparts worked in the interprofessional team. For example, there was no agreed system of IPCC record keeping although a key part of their role was to gather and share information. A second example was the key role that IPCCs had developed in discharge planning and the uncertainty around lines of reporting to nursing on discharge planning activities.

An interprofessional workshop was convened in which matters of accountability around the IPCC role were debated.   The aims of the workshop were to explore:

- The boundary between qualified professionals and 'non-professionals'

- The protective mechanisms that need to be in place to ensure that patients receive best care and that professional accountability is executed in line with legal and professional requirements

- Whether the use of levels of competence and occupational standards should be considered for training, development and supervision.

The discussions resulted in a general need being expressed that the scope, boundaries, working processes and standards of the IPCC needed to be clarified

and formalised, and for nursing to review its role in relation to discharge planning. One ward took the lead in reviewing the nursing role in discharge planning and aiming to establish a more active nursing voice. This included establishing teaching sessions for nursing staff on discharge planning, and aiming to improve discharge documentation and encourage more frequent attendance by nurses at the weekly interprofessional meetings. However, the ward manager who had led this initiative left the organisation two months after this work had begun. It took a few months to appoint a replacement and this led to a loss of momentum in taking the developments forward. One of the IPCCs completed an NVQ Level 3 Module in Customer Care. The IPCCs also set up their own system of documentation. The IPCC job description was also redrafted to better reflect the realities of their work. On occasion, the IPCCs needed to work outside of Trust premises, for example, in visiting patients' homes and this cycle also provided an opportunity to clarify that they were insured by the Trust for this activity.

1.2.3.3 *Third action research cycle: improving interprofessional working*

This action research cycle began in February 2000. Study of the IPCC role had thrown light on interprofessional working generally. It had become clear through the data that the IPCCs had played a valuable role in 'filling the gaps' where aspects of interprofessional care were fragmented. It also seemed that the IPCCs' success in filling these gaps had reduced the imperative for managers and staff in the service to continue to review and improve interprofessional working. A number of issues were identified in this third cycle. The first was a mismatch between the medical teams and the ward bases.

Prior to the study, any consultant could have patients in beds on any of the six wards. This mismatch between the medical teams and the wards meant that there were no cohesive interprofessional teams. Social workers and IPCCs were organised according to medical teams, so each medical team had an allocated IPCC and social worker. Physiotherapists and nurses were organised according to ward bases. These different structures had a fragmenting effect on the interprofessional team, and prevented opportunities for close working relationships to develop between, say, medical and nursing staff.

Another issue was the varying membership and unclear aims of the weekly interprofessional meetings. At these meetings (one of which was held for each medical team), nurses from each of the six wards were expected to attend the meeting to discuss the patients on their ward. In practice, this meant that only nurses located on the ward where the meeting was being held attended the meeting. Often, patients were therefore discussed without representation from nursing staff. Some consultants attended and led the weekly meeting for their team, while other consultants did not. At some meetings, the most senior member of medical staff was a house officer. This variation in membership led to frustrations among frequent attenders of the meetings as to the effectiveness of the decisions that could be taken.

Other issues identified included the need to work towards multidisciplinary documentation, the lack of bleeps or pagers for social workers and junior therapists, and the potential for joint training/case review between staff groups in the service.

Two development workshops were held with interprofessional representation to:

- Share data from this study on interprofessional working, and to consider the patient perspective on interprofessional working.

- Learn from the literature and external visitors about work going on elsewhere to improve the effectiveness of interprofessional working.

- Enable people working in the directorate to identify the key issues in interprofessional working in practice, and to draft an action plan for these issues (if this was needed).

Following clarification of the issues at the first workshop, participants in the second workshop decided on the initial focus of the work. That was in the form of an interprofessional discharge document. Following on from the workshop, a number of interprofessional staff were involved in developing the document and planning its implementation. It was piloted on one ward and, at the close of the study, was about to be piloted across the directorate.

The idea of ward-based weekly interprofessional meetings was also debated following the workshops, but was felt to be unrealistic given the continuing

mismatch between medical and nursing teams. Instead, the clinical director prompted the review and substantial revision of the organisation of medical teams to better promote interprofessional working. This included the medical teams changing their arrangements for admitting patients and adopting a ward-based model of working.

1.2.4 *Reflection phase*

The final reflection phase took place from June 2000. Data collection was concentrated on reflection on the processes and outcomes of the study, and in planning for future change once the study had drawn to a close. In reality, reflection was ongoing throughout the study and the development work towards achieving innovations continued beyond the close of this study. However, during the closing stages of the actual study, it was useful to have a formal reflection phase with key participants to review the study and plan ongoing developments

At the close of the study in July 2000, the following outcomes were identified from the action research cycles:

- Organisation of medical input to wards to change to ward-based medical firms[2]
- Improvement in relations between IPCCs and social workers
- The insurance position of IPCCs working outside Trust premises has been clarified
- Review of nursing practice in discharge planning initiated on one ward but not completed
- IPCC job description reviewed to better reflect actual practice
- IPCCs set up an agreed system of record keeping in their office
- One IPCC completed a Level 3 NVQ Module in Customer Care. Other IPCCs not interested
- Interprofessional discharge document piloted on one ward but not taken further
- Business card with explanation of IPCC role used by IPCCs with some patients and families
- Publication of article about IPCC role in Health Service Journal
- Approximately 40 copies of information pack sent out to other hospitals

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[2] The final change of medical services to a ward-based system took place in 2001 after the study had been completed and prompted the clinical director to work with City University in securing further

The following had been agreed by participants as desirable outcomes but had not been achieved:

- Review of Trust discharge policy which currently names nurses as lead profession in discharge planning and/or review of nursing and IPCC roles in discharge planning

- The agreement and documenting of the IPCC scope and boundaries, professional accountability and supervision, competencies required, working procedures (including documentation and communication) and code of conduct

- Clarification of location of IPCC role in interprofessional team (that is, support worker or equal professional)

- Agreement of suitable training pathway for IPCCs, with possible use of NVQ route.

This story has set out what happened when during the course of the study. It provides rich contextual detail for the reader to judge the relevance of the findings to their own practice situation. What it lacks is the detail of the data collection methods used, the findings uncovered, an analysis of why things happened (and didn't happen), and the contribution these findings make to the wider body of knowledge. These issues are all addressed in the following chapters, a guide to which follows below.

1.3   Introduction to individual chapters

Chapter 2 provides further contextual detail by introducing the social and political context to this study. It examines the policy initiatives that have promoted the development of new roles and describes how a new approach to public sector management characterised by managerialism and marketization has led to a broadening of expectations about who does what in health care. The chapter emphasises the interventionist stance taken by central government in the shaping and delivery of health services.

Chapter 3 comprises the literature review for the study. The chapter illustrates that, prior to this study, very little was known about care co-ordinator and related roles, particularly when they are held by individuals without a nationally registered qualification in health or social care. Particular gaps identified include the issues arising from the implementation of such roles, their progress over time and their

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Trust research funding to evaluate the change. The report from this study indicated that the new system had indeed improved interprofessional working in the directorate (Reeves et al. 2003).

contextual influences.

Chapter 4 outlines the action research approach taken and the methods used for data collection and analysis. Action research is described as being part of a new participatory paradigm in research.

The findings chapters (5-7) illustrate that over time, the IPCCs were charged with doing whatever was required to move patients through their inpatient stay speedily and this flexibility led to a shift in the nature of the work they undertook. Over time, the IPCCs took on work that had originally been undertaken by registered practitioners, by registered nurses in particular, although the IPCCs did not report to any one professional group. These chapters illustrate this role shift, explore its implications in the light of its lack of fit with traditional professional groupings and analyse the wider influences that enabled the shift to happen.

In Chapter 8, the study's findings from the previous three chapters are discussed further and their theoretical and empirical significance explored. The findings are discussed in relation to existing empirical studies and to current theory including the sociology of the professions and theory from the field of organisational change and innovation. The contributions that this work makes to the body of knowledge are highlighted.

Chapter 9 is the final chapter in the thesis. It highlights the implications of the findings for policy, practice, education and research. Recommendations are made for consideration by the reader.

1.4   Final introductory notes

Although this inquiry was a collaborative inquiry, the account shared here is very much my own account. For this reason, the first person has been used throughout the text to emphasis the angle from which the account has been framed.

An important distinction emerges during this thesis between health care practitioners who are members of traditional professional groups and those who are not. As will become apparent, the term 'professional' is socially constructed and it is important that as concrete a distinction as possible is made between these two groups. The distinction that has been used is the possession (or not) of a nationally registered and/or recognised qualification in health or social care that is socially

recognised as conferring professional status. In this thesis, groups with such a qualification include nursing, medicine, social work[3], physiotherapy, occupational therapy, dieticians, speech and language therapy and pharmacy. Members of these groups are referred to collectively in this thesis as staff/practitioners/workers/ individuals 'with a nationally registered (or recognised) qualification in health or social care' or as 'registered'. This group does not include support workers who are members of these groups who may, for example, hold National Vocational Qualifications (NVQs) in aspects of treatment and care.

Individuals who deliver a direct service in health and/or social care to patients but are not a member of the 'registered' group are referred to collectively as staff/practitioners/workers/individuals 'without a nationally registered (or recognised) qualification in health or social care' or as 'non-registered'. This group includes support workers.

The term 'ward manager' refers to a registered nurse in charge of an in-patient ward and its nursing staff.

All staff in the study are described in the findings chapters (chapters 5-7) as female, although participants in the study included male and female participants. Because the male staff in the directorate were of a lesser number, using their true gender risks their identity being known. As for patients and family members, the gender assigned to them in the text is not necessarily their actual gender. Again, the changes that have been made are to protect their identity.

First time abbreviations used in the text are accompanied by an explanation. Thereafter, just the abbreviation is used. An explanation of all abbreviations is summarised on page xi.

A final note is worth making about the desire of staff for the Trust to be named in this work. They are, rightly, proud of their involvement in work of this nature and wanted their contribution to be recognised by a wider audience.

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[3] While social workers have not to date had a national register, this is now changing under the new regulations currently being implemented by the General Social Care Council.

2   Social and political context

This chapter presents a social and political backdrop to understanding the development and operation of the IPCC role and to the analysis of findings that follow later in the thesis.

The IPCC role is a good example of the type of flexible working being promoted in current government policy and its uptake by individuals without 'traditional' health or social care qualifications and/or professional registration also reflects the promotion of a culture in which there are broader expectations about who can do what. This re-shaping of expectations about who delivers health and social care, and in what form, represents a trend of increasing state intervention in the delivery of public services, evident in the UK since the 1980s. In order to appreciate the wider relevance of this study to current UK health policy and the trends it represents, this chapter presents a more detailed examination of health policy initiatives that promote new roles and the use of a managerialist approach in the UK public sector that has led to a greater influence by central government over how health care is shaped and delivered.

2.1   Policy context

Policy developments that promote more flexible ways of working have taken place in a context in which health care needs are shifting, health service technology is developing apace and the availability of health care staff with a professional background cannot meet the demands across the health service (Read et al. 1999). Population health care needs are changing because of an increasingly aged population and a consequent general increase in the prevalence of chronic disease; these changes have implications for the type of health and social care needed (Doyal & Cameron 2000; Royal College of Nursing 2003). In addition, technological advances enabling shorter surgical stays and changing philosophies of care about treatment and rehabilitation (in addition to the economic imperatives discussed further below) have led to a shorter average length of stay in acute

hospitals (Read et al. 1999; Royal College of Nursing 2003). In addition to these shifting factors, recruitment and retention difficulties (in nursing and the therapies particularly) and the imperative to reduce the hours worked by junior doctors have all led to pressures to review professional roles and boundaries in health care (Department of Health 2003a; Malin, Wilmot, & Manthorpe 2002; National Audit Office 2001).

Current New Labour health policy aims for fast, high quality care tailored to individual needs (Department of Health 2000). To achieve this, New Labour has made additional financial investment in the NHS and has also embarked the service on a major process of modernisation. Part of the modernisation promoted through policy is a rejection of demarcations between professional groups. In The NHS Plan (Department of Health 2000), the government states that 'old-fashioned demarcations' between staff mean that some patients see a 'procession' of health professionals resulting in unnecessary repetition of investigations and a lack of sharing of information between staff (p. 27). The document also notes that 'unnecessary boundaries exist between the professions which hold back staff from fulfilling their true potential' (p. 27) and gives examples of areas in which staff 'working flexibly together across traditional boundaries' have achieved more responsive and speedier services (p. 82).

The document further sets out that protocol-based care will 'shatter the old demarcations which have held back staff and slowed down care' and, through this, appropriately qualified nurses, midwives and therapists will be able to undertake a wider range of clinical tasks (p. 83). It is also noted that staff without a professional qualification will benefit from universal access to a formal training pathway and that new national occupational standards for this group will be developed. An emphasis is given to training for new roles, including interprofessional learning and the opportunity for staff to switch careers and training paths more easily.

Underlying these proposals are assumptions that patients want fast and efficient care, and that this is the same thing as patient-centred care. The need for speed, efficiency and staff satisfaction are set out as important drivers of the proposals. However, the term patient-centred care is open to different interpretations, and some commentators have cautioned against the use of assumptions as to what

patient-centred care means, suggesting that perhaps it is patients themselves who are in the best position to judge what is patient-centred and what is not (Coulter 1999; Kendall & Lissauer 2003; Stewart 2001). It may be, for example, that not all patients see speed and efficiency in service delivery as the priority by which services should be shaped and delivered.

These proposals for the modernisation of the health service have continued to be developed and 'fleshed out' since 2000 (Department of Health 2001c; Department of Health 2001d; Department of Health 2002; Department of Health 2003a; Department of Health 2004c). In relation to the development of new roles, the Changing Workforce Programme (CWP) (part of the New Ways of Working team in the Department of Health's Modernisation Agency set up in 2001) was introduced to support the NHS to:

a) 'Redesign staff roles either by combining tasks differently, expanding roles or moving tasks up or down a traditional unidisciplinary ladder

b) Remove any obstacles to change ensuring new ways of working become embedded as a new way of life within the NHS' (NHS Modernisation Agency 2003a, p. 1)

The CWP is leading the development of new roles in pilot sites across the UK and has also developed a number of resources designed to support managers and staff in implementing role redesign locally. These resources include a working differently roles database, a role redesign advice line, toolkits, good practice guides and fact sheets for role redesign (NHS Modernisation Agency 2003a). In *Workforce matters: a guide to role redesign for staff in the wider healthcare team*, the benefits of role redesign are said to include tapping into the 'rich source' of talent and skills in the wider health care team and providing staff with 'unparalleled career opportunities' (NHS Modernisation Agency 2003c, p. 1). This emphasis on the redesign of roles and the development of a more flexible workforce continues to be reinforced in current policy and was reiterated in the Department of Health's recently produced five year plan for the health service (Department of Health 2004c).

Also of relevance here are the Agenda for Change proposals due to be implemented across the NHS from October 2004. These changes introduce a new pay scheme

intended to be comprehensive across all non-medical NHS staff groups. The knowledge and skills framework for the scheme is to be used as the basis for evaluating individual jobs against 22 dimensions including communication; personal and people development; health, safety and security; service development; quality; and assessment of health and well-being needs (Department of Health 2003d). Jobs that include higher levels of skills and responsibility will be paid more than jobs that are comparatively routine. The underlying principle for the scheme is equal pay for work of equal value. The aims of this new scheme are cited as:

- Greater scope to create new kinds of jobs, bringing more patient-centred care and more varied and stimulating roles for NHS staff

- Fairer pay

- Harmonised conditions of service for NHS staff

- A more transparent system of rewards for staff who work flexibly outside normal working hours

- Better links between career and pay progression

(Department of Health 2003c, p. 2)

The information on Agenda for Change given here is relevant because it illustrates how wider systems are being put in place to support the development of new roles.

In the *Workforce Matters* guidance on role redesign, tips include 'there is no right or wrong answer – if it works for you then use it'(NHS Modernisation Agency 2003c, p. 3). This appears at first sight to support local innovation, but the wider policy framework for workforce developments reflects central government desires to disrupt the status quo of what are portrayed as rigid professional boundaries. There is an underlying assumption that current professional groupings do not and cannot succeed in providing fast and efficient care. This imperative for efficiency of resources is set in a context in which efficiency of acute care dominates the political agenda.

At the time these policy developments were initiated, national interest was high in the efficiency of UK health care, especially in the acute sector. Media reports of long waiting times both in Accident and Emergency departments and for elective

surgery reflected extreme pressure on acute resources. The growing demands caused by reductions in the number of acute beds over the 1990s, an increase in the number of emergency admissions and the number of patients awaiting surgery were responded to by a 'recognition' of the need to reduce the average length of hospital stay (National Audit Office 2000). A key report from that time advises that 'hospitals have to ensure that sufficient, but not excessive, resources are available, in terms of beds, clinical and nursing staff and other facilities, to meet the demands of new and existing patients and to co-ordinate their admission' (National Audit Office 2000, p.15).

The UK government's first priority, above all others, for NHS trusts and health authorities was 'to make adequate provision for emergency care' (Secretary of State for Health, 1997, cited by National Audit Office 2000).   Given that this was a central priority, it is perhaps inevitable that other policy initiatives, such as the redesign of work roles and boundaries, were driven by the need for speed and efficiency. This analysis reflects an interventionist stance by central government in setting priorities that drive service developments. It suggests that individual innovations like the IPCC role may not be solely the product of local decision-making based on an analysis of local patient need, but subject to wider influences.

As illustrated above, the interventionist stance of central government over professional role boundaries is set out against a backdrop of professional boundaries portrayed as rigid and inflexible. The flexibility inherent in the IPCC role and its lack of fit with any existing professional group makes the role a good example of the type of new role promoted in current policy.

Although New Labour policy sets out its plans for role redesign as a new thing, challenges by central government to professional boundaries, and public sector working more generally, originated with the Conservative government of the 1980s and 1990s. This approach to public sector management, characterised by managerialism and marketization will now be explored further. This will enable the link between central policy and local development to be clarified further.

2.2   A new approach to public sector management

While the IPCC role was developed locally, that is as a local solution to local issues, its introduction took place in a climate in which broader and more creative

expectations were developing nationally about how health services could be delivered. The impetus for these innovations came from outside of the professions, the groups traditionally 'in charge' of how health services were shaped. This section looks more closely at this new approach to public sector management, in order that the development of new roles such as the IPCC role are seen in the context of growing state intervention.

This section charts the introduction of managerialism into the UK public sector along with the associated principles of marketization. This has been termed 'the new public management', an approach recognised in a variety of international forms (although it is the UK context that is focused on here) (Ferlie et al. 1997; McLaughlin, Osborne, & Ferlie 2002; Osborne & McLaughlin 2002).

2.2.1 *Managerialism*

The rise of managerialism (referred to in some texts as new managerialism) is associated with the challenge initiated by the UK Conservative government in the 1980s to traditional ways of public sector working (Exworthy & Halford 1999). This quote from Pollitt (1993) reflects the main values of managerialism:

> 'the world should be a place where objectives are clear, where staff are highly motivated to achieve them, where close attention is given to monetary costs, where bureaucracy and red tape are eliminated. If one asks *how* this is to be achieved the managerialist answer is, overwhelmingly, through the introduction of good management practices, which are assumed to be found at the highest pitch and most widely distributed in the private sector' (Pollitt 1993, p. 7)

Managerialism in the public sector is a style of management that is distinct from traditional, bureaucratic approaches to management and is characterised by the promotion of private sector or business practices including business planning, the introduction of performance measures and incentives and a disruption of the autonomy of professionals (Dawson & Dargie 2002; Exworthy & Halford 1999; Newman 2002). Managerialism also reflects entrepreneurship, innovation, dynamism and a customer focus (Clarke & Newman 1997; Newman 2002). In this conception, management is seen as a driving force for greater productivity and efficiency, as having a central role in achieving progress and more broadly as a

progressive social force in its own right (Ahmad & Broussine 2003; Clarke & Newman 1997; Malin, Wilmot, & Manthorpe 2002; Pollitt & Bouckaert 2000).

The Conservative government operationalised managerialism in the health service through the introduction of general management in 1983 which gave managers a more proactive voice in shaping health services, and legitimacy to managerial involvement in previously 'no-go' professional domains (Exworthy & Halford 1999; Klein 2001; Malin, Wilmot, & Manthorpe 2002). A more general example of the use of managerialism in the public sector is the creation of Next Steps Agencies through which central government retained a key strategic role in public services but devolved accountability for the execution of policies to agencies at 'arms-length' to government (Ferlie & Fitzgerald 2002; Flynn 1996; James 2003).

Flynn (1997) outlined the four main beliefs of managerialism. Firstly, that people always act rationally and in their own self-interest, and will therefore respond to incentives that recognise this. Secondly, that managers should have the right to manage, and so any forces which threaten this (such as professional organisations) should be weakened. Thirdly, that the private sector is innately superior to the public sector. And fourthly, that competition is the main incentive to improve performance. It is this belief that led to the marketization of the public sector described next.

2.2.2 *Marketization*

Hand in hand with the managerialist approach was marketization, defined here as an application of market principles by the government to multiple aspects of the public sector. Marketization was introduced by the Conservative government of the 1980s and 1990s and developed from an ideological belief in the market as the most efficient distributor of resources and in the need to reduce dependence on welfare state provision (Exworthy & Halford 1999; Malin, Wilmot, & Manthorpe 2002). One important feature of marketization of the health service was the development of a mixed economy, in which private sector providers were able to compete to provide services. There are three core themes to the 'logic of the market': the extension of the domain of activities governed by the market (for

example, the introduction of quasi or internal[4] markets into the health service through the purchaser/provider split); the imperative that the demands of the 'sovereign consumer' are met; and the challenge to occupational, functional and professional monopoly with a celebration of integration and flexibility (Fournier 2000; Klein 2001; Malin 2000).

In conjunction with a managerialist approach, marketization provided challenges to previously professional autonomy in the health service. Examples from the 1990s include detailing through local purchasing contracts the number of clinics a consultant was expected to hold and the development and use of measures that enabled comparison between expenditure and clinical outcome (Malin, Wilmot, & Manthorpe 2002).

Broadening out the expectation of who could provide health and social care also led to the development of a plethora of new roles that challenged traditional roles and boundaries (Denis et al. 1999; Fournier 2000; Malin 2000). These have developed in the context of efforts to develop more flexible labour markets across the economy characterised by low wages, low non-wage costs and a reduction in job security that price marginal workers such as young people, the low-skilled and the long-term unemployed back into jobs (Elliott 2004). The contracting out of substantial portions of health and social care support services such as portering, catering and housekeeping have been representative of these moves.

2.3   Shifting role of the state

Both managerialism and marketization represent a challenge by the state to professional autonomy over the expenditure of resources, including decision-making over professional work (Ferlie et al. 1997; Flynn 1997; Ranade 1997). Under the Conservative regime, it was intended that the market and/or consumer demands would shape the delivery of public services, rather than what professionals decided (Malin, Wilmot, & Manthorpe 2002). This strategy was part of a wider movement in society that was beginning to challenge the degree to which professionals should claim to know what is best for consumers (Exworthy & Halford 1999; Ferlie & Fitzgerald 2002; Haug 1988). However, in the absence of

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[4] Described as 'internal' or 'quasi' market because patient does not pay directly for health care received (Lapsley 2001).

an organised consumer voice or strong market forces, government took on the role of defining what health services should look like (Ferlie & Shortell 2001).

Managerialism represents a culture through which the public sector is more open to political influence through the creation of a culture of command and obedience (Butler 1994; Malin, Wilmot, & Manthorpe 2002). This is in spite of claims that policies such as marketization represented a 'rolling back' of state influence. Clarke and Newman (1997) claim that managerialism represents a rolling out of state power but in newer, more dispersed and more subtle forms.

The use of managerialism as an agent for change, and a number of the principles underlying marketization have transcended changes in government and remain current (Klein 2001; Leatherman & Sutherland 2003; Malin, Wilmot, & Manthorpe 2002). New Labour has continued to promote many of the principles of managerialism and marketization, although with a change in emphasis of some features (Ferlie & Fitzgerald 2002). For example, the Conservative government emphasised financial governance above all for health trusts, while through *A First Class Service*, New Labour charged trust boards with equal accountability for clinical governance (NHS Executive 1998).

A second example is the continuation by New Labour of some aspects of marketization. The annual contracts of the internal market have been replaced with longer term planning agreements and talk of competition has been replaced with the language of cooperation (Ahmad & Broussine 2003; Dixon 2001a; Klein 2001). However, a spilt between service commissioning and delivery and the continuation of hospital trusts with decentralised responsibilities have been retained (Dixon 2001a; Lapsley 2001; Read & et al 2003). The recent introduction of foundation hospitals could also be seen as a further step down this road.

A third example is the degree to which New Labour has challenged the tradition of professional self-regulation, particularly that of the medical profession. Traditionally, the health care professions have relied on professional self-regulation (PSR), although the degree of government involvement in that process has varied (Allsop & Saks 2002). For example, medicine has largely been left to its own devices (Allsop 2002) while nursing has a long history of state involvement in the development and implementation of its regulatory structures (Davies 2002; Davies

& Beach 2000). A recognition of the gaps in current regulatory structures and a series of recent very public scandals, most notably to do with the misconduct of doctors (for example, Harold Shipman and paediatric cardiac surgery at the Bristol Royal Infirmary) (Davies 1999) have led to the government proposing the modernisation of regulation across the board (Allsop & Saks 2002). In contrast to the policy agenda for service development which champions flexibility and the dismantling of traditional structures, the modernisation agenda for professional regulation attempts to tighten control over the professions and to have clear, tightly controlled procedures for accountability and handling misconduct. New regulation of support workers across health and social care is also now being consulted on (Department of Health 2004a), and this represents a more complete regulatory cover of the health care workforce than previously.

While much of New Labour rhetoric is about devolution, many policy analysts have criticised what has been termed a 'command and control' style of government (Dixon 2001a; Dixon 2001b; Harvey 2001; Hunter 2001; Webster 2001). One outcome of a command and control style of government is that actual consumer needs may take second place to other imperatives, and service providers are rewarded for the 'wrong' achievements (Ahmad & Broussine 2003; Hoggett 1996; Leatherman & Sutherland 2003).

Government policy has more recently promoted a shift in the balance of power to front-line consumers and service providers (Department of Health 2001c; Department of Health 2004c). However, as some commentators argue, government, at least for the moment, retains ultimate control (Iliffe 2001; Kendall & Lissauer 2003; Peck 2001; Wall & Owen 2002). Dixon (2001b) notes that 'talk of decentralisation is unconvincing next to the massive structural changes mandated from the centre' (p. 396). For instance, foundation status has only been granted to Trusts that have demonstrated compliance with a range of key government targets, and there is a possibility that each problem that emerges as a result of the increased autonomy of foundation trusts will eventually be dealt with through tighter central regulation (Robinson 2002). As these initiatives to devolve power and award 'earned autonomy' are relatively new, it is too early to tell to what extent the balance of power is actually shifting away from central government.

This analysis highlights the importance of understanding the social and political context of local service developments such as the IPCC role. What influences the development of such roles, how their success is measured, and how they are managed are all important questions. We saw earlier how the development of more flexible working in health care is a key strand of current health policy, and how there may be a degree to which these developments are being driven by the need for efficiency. The above discussion of managerialism and marketization sets this approach to policy by central government in a wider context that goes back further in time than 1997 when the New Labour government was first elected. This degree of involvement of central government in shaping who does what in health care is a relatively recent development and we cannot assume that what is intended in national policy translates either directly into practice, and/or into practice that meets actual patient need. It is therefore important that the study of new policy developments includes a close look at the end results of policy into practice and includes an appreciation of these different contextual layers.

The IPCC role is a good example of a practice initiative representative of current government policy that promotes the development of new roles. This thesis explores some of the issues and implications arising from the development of a new role within the current social and political context of an NHS subject to a variety of influences, including an interventionist central government.

3 Literature review on the care co-ordinator and other new roles

This chapter uses the results of a systematic search to examine the empirical evidence for the IPCC role, and highlights the gaps in the body of knowledge that form the foundation for this study.

This study explores the issues arising from the development of a new flexible role in an acute medical in-patient setting, held by practitioners without a nationally registered qualification in health or social care. Given the emphasis in policy attributed to new and redesigned roles in health care, and to the characteristic of flexibility, the literature search focused primarily on roles that transcend traditional boundaries in health care. This included care co-ordinator and generic roles.

3.1 Search strategy

3.1.1 The initial broad search

The most recent versions of the following databases were searched in June 2004: Cinahl, Medline, Cochrane Database of Systematic Reviews, ACP Journal Club, Database of Abstracts and Reviews of Effects, and Cochrane Central Register of Controlled Trials. A maximally sensitive search strategy was used to identify studies on care co-ordinator roles in health care, generic working and changing roles. Figure 3.1 outlines the details of the search strategy, including the detail of the terms used to guide the search.

All findings were limited to English language, research and systematic reviews, adult care, and published from 1990 onwards. 1990 was selected as this was the year that the NHS and Community Care Act came into effect (Department of Health 1990). It was this Act that introduced the internal market to health care, and subsequently provided one of the most significant challenges to traditional ways of working in health care. Other changes that are frequently cited in the literature as prompting the development of new roles in health care are legislation requiring the

reduction in hours worked by junior doctors (Department of Health 2003a) and the new opportunities for nursing presented by *The Scope of Professional Practice* (UKCC 1992). Both of these changes took place after the 1990 cut-off point used for this review.

The titles, and abstracts where available, of those items identified through this initial search were scanned for relevance to the topics of interest, and relevant items were then retrieved. In addition to items retrieved through the systematic strategy, other relevant items gathered by the author over the past five years were added to the collection of items for review.

Figure 3.1   Initial maximally sensitive search strategy

~((Care) adj (coord$ or co-ord$))
  Continuity of care (MeSH)

~OR

~(Flexib$ or generic or multiskil$) adj (boundar$ or role$ or work$ or prof$)
  Multi-skilled health practitioners (MeSH)

~OR

~Role change (MeSH)
  Entrepreneurship (MeSH)
  (Changing role$ or new role$ or innovation$ or redesign$) (title word)

MeSH – medical subject heading or equivalent
$ - truncation of term
adj – terms appear next to each other

The bibliographies of all items retrieved were then scrutinised to identify further items for inclusion. All items retrieved were subjected to a citation search using ISI Web of Science (using Science Citation Index Expanded, Social Sciences Citation Index, Arts & Humanities Citation Index) to identify other items that included citations to the items already retrieved. Further items of relevance were thus identified.

This initial broad search strategy yielded 194 items. These items were assessed further for relevance, and results were finally limited to research studies of multi-skilled workers and cross-boundary working in health care, particularly care co-ordination activities, and/or new roles through which traditional boundaries had been transcended. All roles reviewed provided a direct service to patients, clients and/or their families.

3.1.2 Distinguishing between studies on registered and non-registered practitioners

While a focus on transcending boundaries was a primary emphasis for the search strategy and the literature retrieved, it was also important to make a distinction between those studies that focus on registered practitioners, and those that focus on non-registered practitioners. This is because the IPCC role was held by individuals without a registered qualification in health or social care. It was clear from the initial review that post-holders in the various studies represented a wide range of backgrounds in terms of training and experience. It was important not to constrain the learning from across this range at this early stage. Distinctions between the findings for registered and non-registered workers are, however, made throughout this review.

3.1.3 Summary of studies selected for review

These decisions resulted in 31 items (26 studies)[5] being selected for the review including 14 studies on care co-ordinator roles (shown in Table A1 in Appendix 1, p. 199), eight on generic roles (Table A2 in Appendix 1, p. 203) and six on other new roles[6] (Table A3 in Appendix 1, p. 207). As the three tables also indicate, 14 studies reported on roles held by registered workers, seven on roles held by non-registered workers and four on a range of roles, some of which were held by registered workers and some by non-registered workers. In two studies, the background of post-holders was not clear (Nash, Grant, & Bartolucci 2000; Pryor 2003). In one study, three different roles were described, one of which was held by a registered worker and two of which did not have the post-holder's background stated (NHS Modernisation Agency 2003b).

Seventeen studies were conducted on UK roles, seven on US roles and four on roles in other countries. No studies were identified that looked at flexible roles, although some of the roles reviewed below identified flexibility as a feature. No studies were omitted due to methodological limitations although these will be identified and discussed below where relevant.

The review of the literature is reported below in three main parts. In Part 1, the specific studies on care co-ordinator roles are comprehensively reviewed to

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[5] A small number of studies had more than one publication retrieved on them.

identify the gaps in the body of knowledge and the methodological strengths and weaknesses of studies to date. In Parts 2 and 3, studies on generic and then relevant other new roles are reviewed with the primary aim of identifying issues about roles similar to the IPCC role, and influences on such roles. The reviews in Parts 2 and 3 were conducted to ensure that the fullest range of influences that may relate to care co-ordinator roles held by non-registered workers were captured, given the methodological limitations of many of the relevant care co-ordinator studies published to date.

3.2   Part 1: Assessing the contribution of literature relating to the care co-ordinator role

As noted above, this part of the review provides a comprehensive review of studies on care co-ordinator roles. Initially, a larger number of studies (n=38) on care co-ordinator roles was retrieved than the 14 finally selected and shown in Table A1 (Appendix 1, p. 199). The range of roles described for a variety of patient groups in different countries was striking, and it was clear at an early stage that rationalisation was needed to ensure that the studies selected had some relevance to the IPCC role. For instance, one study evaluated a telephonic care co-ordination service for pregnant women in the US community (Little et al. 2002). This service was provided within a case management[7] model to improve pregnancy outcome and reduce avoidable clinical resource utilisation. Neither the patient population nor the service provided bore close resemblance to the IPCC role and its clients. Further, many of the studies located outside of the UK were US based and care co-ordination often featured here as a component of a wider community-based case management programme. Given the key differences between UK and US health care provision, the effect that a wider structured programme of support (i.e. case management) may have on a care co-ordinator role, and the tendency of such studies to report on case management rather than focus on the care co-ordination function, these studies were thought to have less relevance.

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[6] This does not add up to 26 because one study (NHS Modernisation Agency 2003b) covered roles in each of the three categories and has therefore been counted three times.
[7] Zwarenstein et al. (2004) define case management as the 'explicit allocation of co-ordination tasks to an appointed individual or group' (p. 1). In US studies, where the term is most often used, it refers to a proactive, community-based service developed in the managed care sector, that uses a total quality management approach to care delivered by senior nurses and social workers based in teams (Cochrane et al. 1999). It can also refer to services involving the use of care pathways.

Two further decisions were made to focus the selection. Firstly, research based studies were chosen which reported on care co-ordinator roles operating in any UK health and social care setting. This yielded eight items (n=6 studies). Secondly, the search was broadened to include studies that reported on in-patient care co-ordinator roles (not necessarily UK). This yielded twelve items (n=11 studies). Given that four items (n=3 studies) met the criteria for both categories, the final number for inclusion was therefore 16 items based on 14 studies. The final 14 studies are illustrated in Table A1. Six are on UK roles, five on US roles and three on roles in other countries.

The following two sections add to the overview of care co-ordinator roles by examining how the roles were interpreted and the background of the post-holders.

3.2.1 Wide range of roles found

The 14 studies report on 16 different kinds of care co-ordinator roles. As Table A1 illustrates, each care co-ordinator study reflects a different interpretation of the care co-ordinator role. For instance, one care co-ordinator role in a US in-patient neuroscience unit took on the following duties: facilitating care by ancillary services; co-ordination of multidisciplinary team conference; facilitating patient care throughout stay; acting as resource person for staff; variance tracking of system problems; and post-discharge follow-up (Counsell, Guin, & Limbaugh 1994). In a second example, experienced district nurses and health visitors took on care co-ordinator roles and worked to 'broker' services for terminally ill cancer patients in the community (Addington-Hall et al. 1992; MacDonald, Addington-Hall, & Anderson 1994). Even the in-patient care co-ordinator roles (see Table A1) demonstrate differences between them, although there tends to be a shared focus on orchestrating the patient admission and discharge planning.

This range of interpretations to the care co-ordinator roles also reflects a lack of consensus as to what work could be classified as administrative and what would be classified as requiring different skill. Three examples are given here to illustrate the diversity of approach between studies. A care co-ordinator role is described in two Canadian medical units (Moher et al. 1992). The duties of the care co-ordinator were described as facilitating administrative tasks such as discharge planning, co-ordinating tests and procedures, and collecting and collating patient

information. However, while this work was described as administrative, it was deemed to require a baccalaureate nurse to carry it out.

In contrast, Kay's (1993) paper describes care co-ordinators working on a UK acute medical ward who took on ward clerking and administration work from nursing. Examples given of such work included booking ambulances, managing bed availability, maintaining ward stock, co-ordinating ward rounds and filtering general enquiries to the ward. This role was taken on by individuals who were 'non-nurses' (p. 34). One post-holder had previously been a ward clerk and the other had previously been an auxiliary nurse.

In further contrast, Reeves et al. (1999a) report on an interprofessional care co-ordinator role (in a pilot to this main study) in which care co-ordinators were charged with ensuring timely clinical investigations; co-ordinating referrals to occupational therapy (OT), physiotherapy and social work; and gathering data on delays. Findings (which are reported in more detail below) reflect a concern from registered workers that the care co-ordinators might inappropriately 'overlap' into their role's territory. These three examples highlight the lack of consensus as to what care co-ordinator work involves and as to whether such work should be classified as administrative or more highly skilled. An examination of the differing backgrounds of the care co-ordinators now follows.

3.2.2   *No consensus on background required*
The studies reflected no consensus on what background is required to be a care co-ordinator. For three of the 16[8] roles described, no detail is given of the care co-ordinators' educational background or previous work experience (NHS Modernisation Agency 2003b; Pryor 2003). Two of the studies (previously mentioned) describe roles taken up by individuals with administrative backgrounds (Kay 1993; Reeves et al. 1999a), whereas, as Table A1 illustrates, registered individuals took up the remaining 11 roles. Nine of these were registered nurses, and six of these nine were nurses with additional skills and knowledge. For instance, Winstead-Fry et al. (1995) describe the background of the care co-ordinator as 'nurses with exceptional clinical skills, communication skills, sensitivity to interpersonal dynamics, and experience and education qualifications'

(p. 49). The two remaining studies that used qualified individuals did not just focus on nursing qualifications. Dant and Gearing (1990) describe post-holders with 'degrees, teaching and nursing qualifications' (p. 348), while the care co-ordinators in the study by Appleton et al. (1997) had backgrounds as clinical medical officers, social workers or community nurses. In three studies of qualified practitioners, the care co-ordinators received additional training for the role before commencing in post (Appleton et al. 1997; Counsell, Guin, & Limbaugh 1994; Nichols & Zallar 1997).

The studies reviewed therefore reflect a majority preference for registered practitioners, often with additional knowledge and skills. However, the lack of an agreed definition of what the care co-ordinator role is, and the use in two studies of individuals with an administrative background complicates this picture. Firstly, the lack of consensus between the studies makes the accumulation of an evidence base problematic. Secondly, the range of interpretations to the role, particularly about what constitutes administrative work and what does not, makes distinctions about who should perform what aspects of work difficult. Thirdly, the preference in the published studies for the use of registered workers means that the evidence base for non-registered workers in care co-ordinator roles is particularly weak.

While care co-ordinator roles are not specifically mentioned in UK national health policy, their development is often described as representing a service over and above 'usual' services, and they often hold a pivotal position in organising the input of a range of different agencies to the care of individuals. While many of the posts appear to originate from within nursing, the above role descriptions that are expanded on in Table A1 reflect roles that often extend beyond the usual scope of one professional group and that are expected to influence the work of other groups as well. These new ways of working and challenging traditional boundaries between staff groups are strongly represented in government policy.

The emphasis in government policy promoting roles like care co-ordination makes it important to study how such roles operate in practice, the issues arising and their overall impact in practice. As this section has illustrated, the range of interpretations to the role and range of perspectives on what the required

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[8] NHS Modernisation Agency (2003) describes three different care co-ordinator roles. This takes the total of different care co-ordinator roles to sixteen.

background is makes comparisons between studies problematic, and the evidence base for non-registered workers in such roles particularly weak. This study attempts to address the gap in relation to non-registered workers by reporting on a care co-ordinator role held by individuals without a registered qualification in health or social care.

The following four sections explore the key methodological weaknesses in studies conducted to date on care co-ordinator roles. They address in turn the claims made for the effectiveness of care co-ordinator roles, the small scale and lack of a longitudinal approach, a lack of attention to context in studies conducted to date and the largely atheoretical reporting of findings.

3.2.3 *Methodological weaknesses reduce confidence in claims of effectiveness*

Nine studies focus largely on assessing the effectiveness of the roles (see Table A1), but the methods used varied in their quality. A general weakness in the quality of methods used, plus the difference in interpretations between the care co-ordinator roles, makes drawing firm conclusions about effectiveness of care co-ordinators problematic.

Two of the nine studies that evaluated effectiveness used a randomised controlled trial design (Addington-Hall et al. 1992; Moher et al. 1992). Randomised controlled trials are widely recognised as the best study design for measuring the effectiveness of an intervention or treatment and these two studies therefore represent the strongest design of the studies that report on effectiveness. There are some weaknesses in design, however, that reduce confidence in the findings reported.

Addington-Hall et al. used a randomised controlled trial design to evaluate the effectiveness of two UK care co-ordinators working with terminally ill cancer patients in an inner London health district (Addington-Hall et al. 1992; MacDonald, Addington-Hall, & Anderson 1994). Care co-ordinator posts were held by experienced and qualified district nurses and health visitors. Their role was to assess the need for and 'broker' services that were routinely available from different agencies; to offer advice on how to obtain these services or to access them for patients; to ensure the services were provided and well co-ordinated; and to monitor the changing need for services of the patients and families. General

practices in the district under study were randomly allocated to either have the care co-ordination service (n=89 practices) or to act as a control group (n=79). Details are not reported of how randomisation was achieved, although practices were stratified by postal district and number of partners. After a period of time (length of time not reported) 13 randomly selected control group practices were transferred to the intervention group as the caseload of the care co-ordinators was judged too small. This process resulted in 318 patients receiving the service and 236 patients acting as the control.

Baseline interviews were held with 281 patients and at least one follow-up interview with 203 patients. In 94 cases, a post-bereavement interview was held with the family. Four years from the time the first care co-ordinator was appointed, a postal survey was sent to 500 local health and social care workers, all of whom had the potential to be colleagues of the care co-ordinators.

Addington-Hall et al. (1992) report no significant difference between the carers' perceptions of effectiveness of terminal care in the intervention and the control groups. There were also few significant clinical differences between the two groups, although the differences that were significant were mostly positive in favour of the intervention group. Intervention group patients were less likely to suffer from vomiting, more likely to report effective treatment for it and less likely to be concerned about itchy skin. Intervention group carers were more likely to report that in the last week of life the patient had a cough and had effective treatment for constipation. Intervention group carers were less likely to report effective treatment for anxiety or the patient having severe swallowing difficulty. Intervention group carers were also significantly less angry when they thought about the patient's death.

The results from the postal survey show that 59% of potential professional colleagues had not heard of the service. Findings show that the care co-ordinators had continued to work largely with their traditional nursing links and the authors postulate that perhaps their nursing background had constrained the potential breadth to the liaison role. This is the only study to identify the limitations of a registrable qualification in a care co-ordinator role.

In spite of the apparent strength of the design, there are some limitations in this study. Although this is a cluster randomised study[9] the unit of analysis reported is that of individual patients not the general practice. The characteristics of patients in the two groups seem broadly equivalent but other differences at the practice level may either amplify or nullify the effect of intervention. The reported analysis in this paper makes no allowance for this 'cluster' effect. The lack of detail on how randomisation was achieved is also problematic. In addition, the change in how patients were allocated partway through the research may also have impacted on the findings, although the analyses included allowance for this change.

Moher et al. (1992) used a randomised controlled trial design to evaluate the effectiveness of a care co-ordinator working across two Canadian in-patient medical units. The care co-ordinator role was focused on facilitating discharge planning, co-ordinating tests and procedures, and collecting and collating patient information. No further information on the intervention is given. Before randomisation, patients were separated into two age groups: over 70 years and 70 years or less. Computer-generated random-permuted blocks in a 1:1 ratio were then used for randomisation. This resulted in 136 intervention and 131 control patients.

The date and destination of discharge were recorded on all patients, as were any deaths. The main diagnosis and any readmission within two weeks of discharge were also recorded. Forty patients were asked on day four of their admission to complete a two-question survey: "During your hospital stay were you kept informed of events relating to your illness?" and "Please rate how satisfied you were with the care you received from the members of the medical team (including the medical team coordinator) during your hospital stay". It is not clear how the 40 patients were selected from the wider group, so the degree to which they were representative of the wider group is not known.

Findings reflect a significantly shorter length of stay for intervention group patients, but no difference between the two groups in the readmission rate. However, the sample size may be too small in this study to reflect any actual difference in readmission, although a difference in length of stay is clearly

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[9] Instead of randomising individuals, groups of individuals are randomised (Puffer, Torgerson, & Watson 2003).

detectable. There was no significant difference between the groups in their perception of being kept informed during their stay. More patients in the intervention group than the control group were satisfied with their medical care, although the use of a brief written questionnaire with a smaller number of patients (n=40) reduces confidence that the findings reflect actual patient satisfaction that could be more widely generalisable. Moher et al. (1992) also did not conduct an economic evaluation and so an assessment of cost-benefit is not available.

Because of methodological weaknesses, the two randomised controlled trials that have been conducted on care co-ordinator roles therefore tell us very little about effectiveness. Perhaps the only findings that can be cited with confidence are the findings from Moher et al. (1992) that indicate a fall in the length of stay and no change in the readmission rate of care co-ordinator patients. Generalising the results from a single site may not, however, be possible particularly in the light of findings on a range of interpretations to the care co-ordinator roles between studies.

A final point to be made about the randomised controlled trials is that both looked at roles held by registered nurses. There are no randomised controlled trials on non-registered staff working as care co-ordinators.

Aside from the two randomised controlled trials, the other seven of the nine studies that looked at effectiveness used a variety of relatively weak methods. Only one of these studies looked at non-registered workers (Kay 1993); this is the study referred to earlier that reports on an administrative support worker to nurses working on a UK acute medical ward. However, although positive benefits were cited including freeing up the time of qualified nurses for direct patient care, no details are given of what methods were used to support these claims.

The other studies looking at effectiveness (in which care co-ordinator roles were held by registered workers or their background was not stated) are weak in design and usually small scale. One study again gives no detail of methods used to evaluate three different care co-ordinator roles, in spite of positive benefits claimed (NHS Modernisation Agency 2003b). One study used a case controlled method for a study including 77 patients (Gow 1999). A patient satisfaction survey (n=not given) and staff interviews (n=21) were used as measures. Four studies measured changes over time before and after the introduction of care co-ordinators, but a

control group or appropriate time series design were not used in any of the studies, reducing confidence in claims that changes over time were due to the introduction of the care co-ordinators rather than other independent variables (Counsell, Guin, & Limbaugh 1994; Nichols & Zallar 1997; Pryor 2003; Winstead-Fry, Bormolini, & Keech 1995).

Length of stay and patient satisfaction were the two most commonly used measures of outcomes in studies that looked at the effectiveness of care co-ordinator roles. As in the Moher et al. (1992) study above, measures of patient satisfaction often relied on the use of structured questionnaire surveys and this may have limited the validity of the findings in relation to actual patient experience. In addition, sufficient detail is not always given of how length of stay is calculated. For instance, Winstead-Fry et al. (1995) report statistically significant decreases in length of stay following the introduction of two care co-ordinator roles in family practice and internal medicine. The authors state that the data used for length of stay comparison is 'MedisGroup statistical data', but without further detail of how these data were gathered and analysed, it is hard to draw conclusions as to the validity of the claims.

A further shortcoming of the studies that look at the effectiveness of care co-ordinator roles is that there are no studies (with the exception of Kay's 1993 study that provides no detail of methods) on care co-ordinator roles held by non-registered workers. While more study on the effectiveness of care co-ordinator roles may reap some benefits, the wide range of roles apparent places a question mark over the utility of studies into the effectiveness of single roles. While empirical generalisation is feasible from randomised controlled trials, it is not possible, for example, to use Moher et al.'s (1992) findings detailed above to conclude that the interprofessional care co-ordinator role explored in this thesis would be equally effective. While (unlike many care co-ordinator roles) there are apparent similarities in the nature of the setting and the nature of the care co-ordinator role (to the extent that they are described), we do not know to what extent the differing professional backgrounds may have on effectiveness and it is not known to what extent, *in practice*, work processes between the two roles may vary. The findings from this section point towards a second methodological weakness

typical of studies in this field, that is a lack of attention to context. This is paid greater attention in the section after next.

Given the difficulties referred to above of accumulating evidence of effectiveness in this field, it may be that more qualitative work has a greater part to play in explicating care co-ordinator work in practice, identifying the issues that arise and the contextual influences on such roles. Some qualitative study has been conducted with care co-ordinator roles, although as the next section illustrates, the work to date has been relatively small scale and relies on data collected at just one point in time.

3.2.4   *Small scale nature and short-term approach constrains utility of findings*
Four studies were identified that used a more qualitative methodological approach (Appleton et al. 1997; Jamison et al. 1999; Reeves et al. 1999a; Smith-Blair et al. 1999) but only one of these studies (Reeves et al. 1999a) examined a care co-ordinator role held by non-registered workers. In addition, there is a tendency for these studies to focus on the initial introduction of care co-ordinator roles rather than following them up over time.

Reeves et al. (1999a) carried out a pilot study of the IPCC role. Three individuals who shared administrative backgrounds held the role. Initial data were collected as the new role was being introduced and gathered through 13 semi-structured staff interviews and two observation sessions of ½ day each. Staff interviewed included care co-ordinators (n=3), managers (n=4) and nursing ward managers (n=6). Six months later, three of the original interviewees were followed up using a telephone interview, but it may be that the lack of an in-depth approach at this stage constrained opportunities to explore issues in detail that had emerged over time.

Findings from the first stage interviews reflect that nursing colleagues interviewed were uncertain about what tasks these new staff could undertake and how best to involve them in the existing work of the interprofessional team. Nurses also raised questions about role boundary overlap, and questioned the care co-ordinators' perceived infringement into the work of other professions. Nursing interviewees were unsure where the boundary limits of the role were drawn and this provoked anxiety. While these issues were reported to diminish over the first six months,

confidence in these findings is limited because they are drawn solely from three telephone interviews.

As noted above, this is the only study using more qualitative approaches that examined a role held by individuals without a registrable qualification. The relative lack of a longitudinal approach means that we do not know what happens to care co-ordinator roles held by non-registered workers over time. Given the importance of the issues raised in this pilot work, the need for further work over a longer period of time is evident. The small scale size of the pilot work (that is, the small number of interviews conducted, the lack of representativeness of the full membership of the interprofessional team and the small scale nature of the observation work) also indicate that more study is needed to test out these findings on a wider scale.

Two of the studies on registered workers in care co-ordinator roles focus solely on the role's introduction (Jamison et al. 1999; Smith-Blair et al. 1999). In one of these studies, observation (at least four hours but no further details given) and 17 'formal and informal' (p. 357) staff interviews were used to explore the introduction of a care co-ordinator role to a US medical-surgical unit (Jamison et al. 1999). The care co-ordinator was a registered nurse with at least 2 years clinical experience and a bachelor's degree in nursing. The key duties of the role were the development and implementation of care pathways and an evaluation of patient outcomes. Interviewees included managers, nurses, administrative staff, social workers, a doctor and a physiotherapist. This inclusive approach makes it more likely that the views shared by interviewees represented the broader interprofessional view.

The authors report that the role's introduction was accompanied by issues of role ambiguity and the need for the care co-ordinator to go through the process of 'making the role'. Role ambiguity was related to a lack of clarity as to what activities the role should focus on, a lack of adherence to the requirement that post-holders would have a bachelor's degree in nursing, a difference in interpretation of the role between individual care co-ordinators and a lack of planning for the physical needs of the post-holder (for example, office space). The process of 'making the role' of care co-ordinator included communicating the vision (through staff training and information); gaining new knowledge (training for the care co-

ordinator); accessing resources (including mentors, developing collegial relationships with other health professionals); and defining boundaries. The process of defining boundaries highlighted a trade-off between role flexibility and clear expectations. The flexibility was welcome, but the lack of clear expectations of the role created discomfort. Other parts of the process of defining boundaries included clarifying the focus of responsibility (decided as service-specific rather than unit-specific so that patients could be followed through from admission to discharge) and the need to distinguish the role from other similar roles.

Training needs for the care co-ordinator were also identified including the need to develop skills in leadership and information technology, and gain knowledge in differentiated practice models, managed care, clinical pathways and insurance regulations. No study beyond this initial introductory period is reported and so it is not possible to know if new training needs continued to emerge.

As mentioned above, this study does not report on what issues emerged beyond the initial introduction of the role and it is therefore not known how these important issues developed over time or if any new issues emerged. In addition, while an in-depth approach is indicated from a description of the methods, the lack of reporting of the hours spent in participant observation or the number of formal interviews undertaken means that we cannot know the degree of certainty to attribute to the findings.

In the second qualitative study on registered workers Smith-Blair et al. (1999) used a phenomenological approach to explore the introduction of two care co-ordinator posts (apparently held by registered nurses but not completely clear) on a US medical-surgical unit. Methods included 11 staff interviews, 32 hours of observation and documentary analysis. Interviewees included care co-ordinators, nurses, a physician and a manager. This inclusive approach makes it more likely that the views shared by interviewees represented the broader interprofessional view.

Smith-Blair et al. (1999) found a context of constant change with regard to nursing skill mix, the creation of new nursing roles and changes in the type and acuity of patients. In addition, staff interviewed routinely cited increasing demands on staff time made by increasing acuity of patients. This study is the only study that makes

any mention of wider contextual issues impacting on the care co-ordinator role. In relation to the role itself, staff reported issues of role confusion, apprehension and fear alongside hopes that the role would be of benefit to patient care. Role confusion stemmed from uncertainty about what exactly the role was supposed to accomplish, the confusion being most pronounced in staff already engaged in patient care planning and discharge. There were also territorial concerns about how the care co-ordinator role was positioned in relation to existing roles and responsibilities.

Again, issues that emerge beyond the initial introductory period are not reported, and it is not therefore known how the issues identified here develop or what new issues emerge. A clear picture is given of methods used and this indicates an in-depth approach was taken to study the introduction of this role, although it is still relatively small scale.

In the third qualitative study on registered workers, 12 care co-ordinators of varying professional backgrounds (registered nurses, social workers and doctors) co-ordinated the transition to nursery school of UK children with a disability[10] (Appleton et al. 1997). The intervention lasted nine months and was provided up to the child's entry to formal nursery education provision. The service included a structured assessment focusing on child and family needs, a care plan including a school transition plan, continuity of availability for parents throughout the period of transition, and co-ordination of case reviews. Prior to the uptake of their posts, care co-ordinators received training for each of these tasks.

Parents of 20 children agreed to participate in the project. Structured family and care co-ordinator interviews were carried out approximately three months after nursery school entry. No further details of method (for example, length of interview, nature of questioning) are given so it is hard to judge the quality of methods used. It is also not clear how many families were interviewed. Eleven (out of a possible 12) care co-ordinators were interviewed.

Seventeen families interviewed felt they received enough care co-ordinator contact and 15 felt the care co-ordinator 'always' listened to their concerns. Interviewees (n=not known) 'spontaneous[ly]' remarked on the importance of the care co-

ordinator being able to sort out appointments, referrals and access to resources, and 18 families reported no service co-ordination problems at interview.

Care co-ordinators (n=11) identified a number of issues including a lack of time for care co-ordination; awareness of learning needs for parent empowerment, care plan and review, listening and counselling; and the importance of providing full care co-ordination earlier in the child's life.

These findings are valuable because they, unlike the other qualitative studies, report on a care co-ordination service at a point in time beyond its initial introduction. However, the reliance on one set of interviews at one point in time where scant detail of method is given, raises concerns about how representative the findings are of the picture over time.

In spite of the methodological shortcomings identified, these four studies indicate how a more qualitative approach can uncover important issues.   The findings from these studies suggest introducing care co-ordinator roles brings uncertainty about the boundaries of a role that transcends traditional boundaries and, in the event of a range of different backgrounds new care co-ordinators bring to the job, an uncertainty of what post-holders can contribute that is different to existing contributions in the interprofessional team. However, in the studies that identified such issues, we do not know how these issues developed beyond their initial introduction. Training needs were also identified by two of the studies on registered workers (Appleton et al. 1997; Jamison et al. 1999). The only study of this kind to focus on a care co-ordinator role held by individuals without a registered qualification is limited by its relatively small scale and the subsequent lack of opportunity to explore the emerging issues in more depth (Reeves et al. 1999a; Reeves et al. 1999b).

All of the studies reviewed up to this point (including those in the previous section) reflect a lack of attention to the passage of time as a factor. This is reflected in a tendency to take a cross-sectional approach to data collection, usually evaluating the role at just one point in time. This approach suggests a static view of care co-ordinator roles in spite of the fact that they may shift and change in practice in

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[10] While the search strategy focused on studies on services for adults, this study was included because the care co-ordination service was provided to the child and their family.

terms of their characteristics, impact and effectiveness. In addition, studies reviewed are relatively small scale and do not convey a rich picture of actual practice or the in-depth perspectives of multiple stakeholders on the care co-ordinator role.

3.2.5   *Lack of attention to contextual factors*

None of the studies reviewed involved the systematic collection of data on contextual influences on the role or allowance for these factors in either study design or reporting of findings. This is problematic in a number of ways.

With regard to the randomised controlled trials detailed above, there is a case for viewing the results of single-site randomised controlled trials as single case studies in which experimental evidence of effectiveness is embedded (Griffiths 2002). This view highlights the importance of a rich and detailed description of study context, the features and processes of usual (or baseline) care and the features and processes of the intervention.   Attention to these details will enable the generation of hypotheses about the potential causative factors at play (Griffiths 2002). As Griffiths (2002) notes where precise replication is not possible (and this is often the case in health services research), it is insufficient to know whether or not something worked; we need to also understand why it is effective.

Neither Addington-Hall et al. (1992) nor Moher et al. (1992) provide sufficient contextual detail of this kind. Addington-Hall et al. (*ibid*) provide a fairly detailed description of what the care co-ordinators' role was but fail to distinguish this adequately from usual services. Only scant details are provided of local context. In Moher et al.'s (1992) randomised controlled trial (*ibid*), only broad detail is provided about what the care co-ordinators' role is (and no data are gathered on this in practice to ascertain if, in fact, actual practice matches the intentions for the role). In addition, no information is provided about usual services in relation to discharge planning, coordinating tests and procedures and collecting and collating patient information (all duties taken on by the care co-ordinator). Again, details of the other features of the local context are scant.

The Medical Research Council has recently developed a framework for the design and evaluation of complex interventions to improve health (Campbell et al. 2000). This framework reflects a process of evaluating complex interventions that is

iterative and phased. A process is recommended that begins with modelling or simulation of the intervention, descriptive studies to delineate variants of a service and qualitative research to show how the intervention works and identify potential barriers to change. From this point of view, in the apparent absence of such preliminary work, perhaps randomised controlled trials on care co-ordination are premature.

Context has already been examined in relation to the randomised controlled trials, but a brief illustration of this shortcoming will now be made with regard to the other effectiveness studies. As has been pointed out, positive changes over time claimed by these studies cannot be confidently attributed to the intervention of the care co-ordinator role alone. Not only have factors such as context (for example, new government targets on length of stay, changes in provision of community services, or other service innovations or changes) not been systematically controlled for in design, a general lack of attention to context means that the potential importance of these factors is not even acknowledged. For instance, Nichols and Zallar (1997) report reductions in length of stay over time following the introduction of a care co-ordinator role, but do not acknowledge that there may have been other contextual factors that also impacted on length of stay. These shortcomings are common to studies looking at effectiveness, and can be a function of the focus on the collection of quantitative data alone.

Three of the four qualitative studies reviewed above also fail to pay attention to the importance of context (Appleton et al. 1997; Jamison et al. 1999; Reeves et al. 1999a). In these three studies, opportunities are missed to explore how the context may have shaped the development and introduction of the role, and how participants viewed the issues. No data were collected on wider influences on the role, the study concentrating solely on the issues that arose. For instance, in Reeves et al.'s (1999a) study, interviewees cited the benefits of the role as including reducing unnecessary delays to patient discharges and saving the time of other staff that had been spent on administrative work. However, no detail is given of the study context including what the pressures were to reduce delayed discharges and/or to optimise the use of staff time.

In contrast, Smith-Blair et al. (1999) do present their findings on staff experiences of the new role in relation to findings on key contextual elements. The three main

elements identified are 'constant change', 'demand and time' and 'setting the stage' (p. 342). 'Constant change' relates to a series of significant changes taking place over the 18 months prior to the introduction of the care co-ordinator role. These included the introduction of external consultants to redesign care resulting in alterations in the staff mix, the appointment of a new nurse manager, the creation of two new nursing roles (not including the care co-ordinator role) and changes in the type of patients on the unit that had resulted in an increase in the acuity of patients. 'Demand and time' relates to an increased patient demand leading to decreased availability of time, and a lack of experienced staff to respond to the new demands being made. 'Setting the stage' relates to a number of issues related to implementing the role. These included unexpected budgetary constraints forcing a change in the way the care co-ordinators organised their input, and the lack of resolution of how the care co-ordinator role was to be distinguished from other similar roles.

These key findings from Smith-Blair et al.'s (1999) study highlight the importance of contextual detail in framing and understanding other findings. The contextual details provide a richness to the findings that make it more likely that the reader can judge the 'fittingness' or similarity (Lincoln & Guba 2000b) of the study context to his or her own setting. They also serve as important findings in their own right, illustrating the wider influences at play in a health service setting.

In summary, care co-ordinator studies to date pay very little attention to study context, either in relation to describing their findings or as an additional source of data. As a consequence, there is a lack of understanding as to what shapes the development of care co-ordinator roles and then influences their progress. Opportunities are also missed to understand why, when there are indications of effectiveness, such roles are effective.

3.2.6   *Reporting of findings largely atheoretical*
In addition to the general lack of attention to context in the care co-ordinator studies, there is also a tendency to report study findings in the absence of available theoretical frameworks. This practice misses opportunities to contribute the findings from these individual studies to the wider body of knowledge, but also to appreciate the findings in their wider theoretical context. Three of the four

qualitative studies reported above do report their findings in the context of theory and these are the only care co-ordinator studies to do so.

Reeves et al. (1999a) use a range of theories against which to explain their findings. These include theories of role stress and role strain, insights from the interprofessional literature into the need for role clarity, the influence of post-Fordist ideas on the development of more flexible occupational roles, and the explanatory power of the negotiated order perspective in viewing the central role of negotiation of the new role (Handy 1976; Lyons 1993; Opie 1997; Piore & Sabel 1984; Strauss 1978). Jamison et al. (1999) set their findings in relation to the role theory concepts of role ambiguity and role making (Hardy & Conway 1988), while Smith-Blair et al. (1999) set their findings in relation to sense-making theory (Weick 1995).

In summary, with the exception of three of the four qualitative studies reviewed, reporting of findings is atheoretical.

3.2.7   *Summary of the literature relating to care co-ordinator roles*
In summary, very little research has been done on care co-ordinator roles held by non-registered workers. The difference in interpretation of the care co-ordinator roles between different study settings and differences in the background of post-holders makes the accumulation of an evidence base problematic. Studies of effectiveness claim that such roles in an in-patient setting can be of value in reducing length of stay and improving patient satisfaction, but methodological weaknesses reduce confidence in these findings.

Issues of role confusion and boundary overlap were also identified. Small scale studies that have explored the process of introducing care co-ordinator roles indicate feelings of uncertainty about this new role, particularly about what post-holders can contribute that is different to the existing contributions in the interprofessional team. Only one of these studies looked at care co-ordinators without a registrable qualification and this was a pilot study. We therefore cannot draw firm conclusions about the issues identified in relation to this group of workers.

Two studies on registered workers identify that training issues emerge after the role has been introduced but more work here would be of use.

We also know very little about issues that emerge over longer periods of time and this gap reflects a static view of such roles in spite of the fact that they may shift and change in practice in terms of their influences, characteristics, impact and effectiveness.

Only one study identified contextual factors impacting on the care co-ordinator role but no other studies sought these factors out. Given what we know about how factors such as government targets or resource constraints can influence how services are shaped, it is surely relevant to use studies of specific initiatives such as these to look at the wider factors that are shaping these roles in practice and influencing their development. To date, however, this has not been done in relation to care co-ordinator roles. While a small number of qualitative studies drew on appropriate theories through which to explain their findings, there is a tendency among the studies as a whole not to draw on the wider literature when presenting their findings.

Casting the net wider to look at roles that have similarities to the IPCC role may throw light on some of the gaps in knowledge identified by looking at care co-ordinator roles alone. The following two sections will therefore review, in turn, generic roles, and other workers in new roles that transcend traditional boundaries.

3.3 Part 2: Assessing the contribution of literature on related generic roles

Generic roles are relevant here because they imply flexibility around traditional boundaries that is key to the IPCC role. No items were retrieved on 'flexible' roles in spite of their prominence in government policy, but the concept of generic working is one example of how the feature of flexibility can challenge traditional boundaries. A generic role is defined here as a role which takes on the work of more than one traditional role, usually taking on aspects of multiple roles. This is a key feature of the IPCC role, although not particularly reflected in the role descriptions of most of the care co-ordinator roles reviewed above. As with the care co-ordinator roles, generic roles reflect a wide range of interpretations and there is perhaps little value in attempting absolute distinctions between, for example, care co-ordinator and generic roles. What is perhaps of greater value is the approach taken here that recognises similarities between the two types of roles and uses these similarities to explore the extent to which generalisations may be

possible from the generic literature to add to our understanding of care co-ordinator roles.

Eight studies were retrieved in this part of the search and Table A2 (p. 203) illustrates the detailed findings of the review. As Table A2 indicates, four studies report on generic roles held by non-registered workers, two on roles held by both registered and non-registered workers, and one on a generic role held by registered workers. In one study, it was not clear what the background of the post-holders was. Five studies report on UK roles, two on US roles and one on Canadian roles.

Many findings from the studies on generic roles are similar to those on care co-ordinator roles in the previous section and so will not be covered in detail here. These shared findings include a range of interpretations of generic roles including their uptake by individuals with and without registered qualifications, a relative weakness in methods used to evaluate effectiveness and a general picture that outcomes are positive. Studies on generic roles also identified educational issues, and issues of role confusion and boundary overlap, but the findings on generic roles provide additional knowledge in these areas and it is this new knowledge that is concentrated on here. What the studies on generic roles bring that is new is the issues arising from roles that take on the work of more than one traditional group. It is these issues that are concentrated on here.

In addition, as is evident above, there is a greater proportion of non-registered workers in generic roles than care co-ordinator roles in the published studies and these findings therefore help to shed light on what the issues may be for the IPCC role.

3.3.1 *Issues suggested about lack of depth of a generic training*
The eight studies reviewed reported between them on at least[11] 15 generic roles. As Table A2 indicates, two studies report on roles held by both registered and non-registered workers, one on a role held by registered workers and four on roles held by non-registered workers. In one study, the background of the generic workers was not clearly stated.

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[11] In one study, it was unclear how many different generic roles were being reported on (Hurst 1995).

The literature in this area generally indicates that individuals taking up generic roles need additional training regardless of background and this appears related to the recognition that training is needed when taking on part or all of the work of an existing occupation (Anderson 1997; Hurst 1995; Nash, Grant, & Bartolucci 2000; NHS Modernisation Agency 2003b; Pischke-Winn & Minnick 1996; Rolfe et al. 1999; Shield 2002). This applies to individuals both with and without an existing qualification. Some of the UK studies cite the need for nationally recognised qualifications such as NVQs for individuals without a registered qualification (Rolfe et al. 1999; Shield 2002), but others do not give details of educational or training requirements.

Rolfe et al. (1999) used an action research approach to explore staff attitudes to the prospect of a generic support worker (that is, a non-registered worker) in a UK rehabilitation unit. Methods included 4 semi-structured group interviews with the prospective support workers and with registered practitioners, a visual analogue scale to measure attitudes to and satisfaction with the service (*n* not given) and an 'ethnographic snapshot over several days' (p. 328). As far as can be judged given the lack of methodological detail, this represents a small-scale study. Rolfe et al. report that qualified professionals expressed concerns about the proposed training course intended to prepare the support workers for their generic role prior to starting in post. The education programme was aimed at health care support workers from a variety of disciplines and aimed at developing competencies at National Vocational Qualification (NVQ) levels 2 and 3. Qualified staff felt that a perceived lack of depth to the training programme might lead to the support workers 'having a go' without anticipating the full consequences of their actions (p. 332). Both support workers and qualified staff felt that the proposed training might not be adequate to meet the expectations of the role. This study did not follow the programme through to implementation of the role so it is not possible to know if these anxieties were realised.

The literature here indicates that training may be required prior to the uptake of generic roles, but that there may be issues concerning a lack of depth to education that necessarily covers the work of more than one occupation. The lack of a longitudinal approach to study method means that we do not know what the educational issues are in practice. The work of the IPCCs in the territory of more

than one occupational group indicates that these findings have some relevance to the evidence base for IPCCs but more work is needed here.

3.3.2 *Accountability issues not clear for generic support worker roles*

As with the care co-ordinator roles, generic roles raised issues of boundary overlap and role confusion, but the studies on generic roles also point to a lack of clarity of accountability for the work of generic support workers. This lack of clarity was related to the detachment of generic roles from any one professional group and the related regulatory structures that are uniprofessional in nature.

Interviewees in Rolfe et al's (1999) study (see previous section) thought that there would be both positive and negative consequences of blurring the boundaries between the work of nursing, physiotherapy and occupational therapy. Anticipated positive benefits included a more holistic view of patients' needs and an extension to existing staff knowledge and skills. However, support workers felt insecure about a perceived loss of belonging and status associated with individual professional groups, and were unsure which professional group would provide them with support or advice regarding care decisions. Qualified professionals felt that responsibility and accountability issues were not clear, and also felt threatened at the prospect of a 'subprofession' taking over some of their own roles (p. 329). Both non-registered and registered workers felt that, given the multiple professions that would be dictating treatment plans to the support workers, clarity had not been achieved about who would be responsible should something go wrong.

Shield (2002) reports on a study of a proposed UK interprofessional practitioner for older people. Methods used included a written questionnaire distributed to 150 multidisciplinary teams providing services to older people, interviews with 24 older clients, interviews with two carers' groups (total n=22) and interviews with chief executive officers and senior managers from the Chartered Society of Physiotherapy, The College of Occupational Therapists, The Royal College of Speech and Language Therapists and the Royal College of Nursing (*n* not given). Much of the exploration conducted was focused on developing an educational framework for the proposed practitioners. The findings do, however, also identify the need to establish how and where these new practitioners would be regulated,

and point towards the development of the Health Professions Council[12] as providing a potential solution. However, no further detail is given of the views of those interviewed/surveyed on this particular matter and this is disappointing given the potential relevance of this discussion to the IPCC role. Neither Shield nor Rolfe et al. (1999) report on whether or not the issues raised prior to implementation were still in place after the proposed posts were introduced.

There are two main similarities between the IPCC role and generic support worker roles. Firstly, they are taken up by individuals without a registered qualification and, secondly, they take on the work of more than one existing occupation. Findings from the studies on generic roles suggest that there may be a lack of clarity about who is accountable for the work of such staff, but the lack of study of these roles in practice represents a significant gap in the body of knowledge.

3.3.3 Summary of the literature relating to generic roles

In summary, there is a range of different interpretations of generic roles, and individuals from a range of backgrounds fill them. The small amount of study that has been done on educational needs suggests that concerns exist about the lack of depth to training support workers into generic roles, but no work has been done that looks at these roles in practice and what can be learned about educational issues from practice.

In the two studies of roles that most closely match the IPCC role, a lack of clarity about accountability and responsibility is evident (Rolfe et al. 1999; Shield 2002). The findings identify a lack of clarity for practitioners whose work covers the territory of more than one professional group and raise questions about 'where the buck stops' in terms of professional regulation and accountability. Again, neither of these studies look at the role in practice to determine whether the concerns raised by respondents translate into reality.

As with the care co-ordinator studies, no findings emerged that identify wider contextual issues to the generic role. This may be due to a tendency towards data collection over relatively short periods of time and therefore a lack of opportunity to develop a broader understanding of wider issues impacting on the role. The

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[12] This new council oversees the regulation and registration of health professions, including newly developed groups.

action research approach used by Rolfe et al. (1999) may have led to a more in-depth relationship between researchers and ward staff, but the relatively short length of time of the study and relatively small scale of data collection perhaps mitigated against the identification of wider issues. The reporting of findings on generic roles has not been done in the context of theory and this obscures the wider generalisability of the findings.

As with the care co-ordinator studies, reports on generic roles reflect an apparent tendency to evaluate roles that were newly (or not yet) introduced rather than track their course over longer periods of time. This means there is no evidence base to guide the management or use of these roles once their introduction is complete.

Given the gaps in the knowledge that remain from the review of care co-ordinator and generic roles, it is now necessary to cast the net even wider to see if the study of other new roles that transcend traditional boundaries helps to shed light on accountability, responsibility and regulation; on the progress of new roles over longer periods of time; or on wider contextual issues that impact on new roles.

3.4 Part 3: Assessing the contribution of literature relating to other new roles

This section assesses the contribution of studies of other new roles that transcend traditional boundaries. A wide range of roles was initially considered for inclusion in this section, ranging from nursing-led in-patient services to community mental health support workers (Griffiths & Wilson-Barnett 2000; Murray et al. 1997). Many of the studies were based in the UK, with 23 out of the 31 studies focusing on mainly (or all) nursing roles.

Six studies were selected from this range. These studies were selected because they report on roles that transcended traditional boundaries in health care and threw light on accountability, responsibility and regulation; on the progress of new roles over longer periods of time; and/or on wider contextual issues that impact on new roles. The six selected studies are shown in Table A3 (p. 207). As Table A3 indicates, three of these studies report on roles held by registered workers, one by non-registered workers and two on roles held by both types of worker. All are located in the UK.

As indicated earlier, NHS Modernisation Agency (2003b) gives scant detail of evaluative methods used. In contrast to this, the other five studies are methodologically strong (Murray et al. 1997; Read et al. 1999; Read & Graves 1994; Roe, Walsh, & Huntington 2001; Woods 1998). A case study approach is commonly used, with a range of in-depth qualitative and quantitative data that is appropriate for drawing out detailed issues. All of these five studies look at the new roles over a range of settings and patient populations, and in one study a longitudinal approach was taken to track changes over time (Woods 1998).

Although it was not always well documented, these five studies generally reflect the study of roles that, although established by the time of study, were new in concept and/or design relative to more traditional roles. Read et al. (1999) articulate this approach the best, although other researchers seem to be working from a similar basis. Read et al. included roles that had been in place for at least six months and that 'were innovative, non-traditional, or taking on aspects of care previously believed to be the work of another group of health professionals' (p. 26). The methodological strength of these studies and their location in the UK mean that greater weight can be attributed to the findings for the purposes of this review. However, three of the studies look at new roles undertaken solely by practitioners with a nationally registered qualification and most roles reviewed in this section have increasingly less relevance to the care co-ordinator role. In addition, one of the studies that looks at both registered and non-registered workers concentrates mainly on registered workers with just a few exceptions (Read et al. 1999). These factors may limit the generalisability of the findings to a role such as the IPCC role. Differences in educational background and work experience are discussed further below.

Each of the three knowledge gaps identified from the care co-ordinator and generic working literature will now be addressed in turn, to determine what this body of literature can add. This means that some findings from these studies will not be discussed.

3.4.1 Accountability, responsibility and regulation
Issues of accountability, responsibility and regulation generally accompany new roles that transcend traditional boundaries.

Murray et al. (1997) studied the caseload of 62 support (that is, non-registered) workers in community mental health. They report a role overlap with social workers, and in particular with community mental health nurses. Support workers and users reported that the support workers were 'heavily involved in providing emotional support, helping with social networks and helping users communicate with families' (p. 25). This is an example of boundary overlap of individuals without a registered qualification taking on the work of registered nurses, and in some cases qualified social workers. It provides a good opportunity to look at issues of accountability and regulation for individuals with similar backgrounds carrying out work previously carried out by registered practitioners.

Separately to the activity analysis, Murray et al. (1997) interviewed a range of people from the mental health field (n=50). Some interviewees saw the support worker role as an assistant role to the professional practitioner and felt that support workers therefore needed close, direct supervision. These individuals expressed concerns about support workers not understanding confidentiality fully or becoming 'over-involved' (p. 11) with users. Most interviewees however did not share these concerns but still felt careful recruitment, appropriate training and professional clinical supervision (individual and group) were required. The key value of support workers was seen to be the 'breadth of their potential remit' (p. 12). These findings present a mixed picture, but indicate that such service developments need to be supported by thoughtful recruitment, training and professional supervision as a minimum requirement. The main limitation of these findings is that they are based on the opinions of a range of senior individuals from the mental health field. These interviewees may not have had any contact with the practice of the support workers or the issues arising from this practice. More study that examines these issues directly in practice would be of value.

Three studies (on all or mainly registered workers) highlight that the emergence of issues of accountability, responsibility and regulation often resulted from an inability of national policy and legislation to 'keep up' with developments in practice (Read et al. 1999; Read & Graves 1994; Roe, Walsh, & Huntington 2001). Examples cited include the lack of legislative support for nurse prescribing, a lack of national policy on nurses substituting aspects of medical work such as requesting X-rays and a lack of clarity on which professional body would cover

role functions in, for example, the event of a registered nurse taking on medical work. The most common boundary overlap cited in this literature is that of registered nurses taking on aspects of previously medical work and this is reflected in the examples used here.

A range of findings highlights this lack of national direction. Read et al. (1999) studied a range of new nursing and professions allied to medicine (PAMs) roles in 40 acute Trusts across England. Methods included the mapping of the range and purpose of the new roles through interviews with nurse directors (n=40), post-holders (n=not given) and their managers (n=not given); the exploration of 32 case studies including observation, semi-structured interviews, discussion groups, documentary and Trust data review; and the completion of a postal questionnaire to all post-holders.

Findings from Read et al's study (1999) reflect that new roles were commonly associated with complex lines of clinical, managerial and professional accountability that were often poorly defined and not well understood. Also reported is a range of approaches to assessing the competence of post-holders and a lack of consistency as to who was responsible for this assessment. A lack of clarity in professional insurance and legal indemnity follows on from this complex picture. Read et al. also found that the tendency for new roles to develop over time meant that job descriptions and accountability arrangements developed at the outset of the job often bore a poor resemblance to what was needed by the time the study took place. Read et al. mainly studied new roles taken up by individuals with nationally registered qualifications but pointed out that there are even more profound implications of these issues for those without a professional health care qualification who take on new roles. However, data were not gathered directly on this issue.

In their study on (registered) nurses working in personal medical services (PMS) pilots Roe et al. (2001) found a growing overlap between the work of nurses and general practitioners (GPs). Methods included three workshops with 12 nurses, and in-depth interviews with nurses and key stakeholders in four case study sites (n=18). Both nurses and doctors interviewed felt comfortable when there was regular communication, maintenance of a dialogue between doctors and nurses, and a felt confidence by GPs in nurses' competencies. Most also found that agreed

treatment protocols and care pathways helped to maintain 'safe and accountable limits' (p. 12). These findings reiterate the need for close attention to be paid to areas of boundary overlap, and the need for a range of issues to be looked at. Again, this study was on individuals with nursing registration, and this may limit the generalisability of the findings to those without equivalent qualifications.

In addition to findings that re-iterate the need for formal training prior to the uptake of a new role, studies in this section also indicate the value for practitioners in new roles of access to mentoring and clinical supervision (Murray et al. 1997; Read et al. 1999; Roe, Walsh, & Huntington 2001).

In reporting on new roles developed in the pilot phase of the Changing Workforce Programme (CWP), the NHS Modernisation Agency (2003b) emphasises the need to ensure through contracts and local codes of conduct that new staff are clearly aware of their responsibilities and accountability, and that redesigned roles require clear protocols and guidelines including what limits of a person's responsibility are. The lack of detail of method used and the overtly positive style of writing in this report obscures the issues that led to these recommendations, but perhaps one can surmise that the introduction of new and redesigned roles in the pilot phase of the CWP did raise issues in this area.

In summary, when new roles transcend traditional boundaries, and individuals are carrying out the work of two or more professional groups, it is not automatically clear to which profession that individual is ultimately accountable, which profession is responsible for assuring competence, and who is ultimately accountable should something go wrong. The lack of national policy in this area means that clear local arrangements need to be in place. The one study that has looked in more depth at these issues for individuals without a registered qualification indicates that these matters are even less straightforward than for registered practitioners (Murray et al. 1997), but, as with the findings on generic workers in the previous section, more study that examines these issues in practice would be of great value here.

3.4.2 *Progress of new roles over time*
There is very little in the literature that examines the progress of new roles over time. The one study that took a longitudinal view (a 12 month full-time training

course for nurse practitioners followed by six months of practice) does not report on findings that indicate changes over time (Woods 1998). The strength of studies in this section compared to previous sections is that they apparently mostly take place after the new role has had time to 'bed in' (although this is not well documented). This gives a clearer idea of the issues that arise after the initial introductory period.

In their study also drawn on above, Read et al. (1999) found that, for many respondents, their role had changed substantially since the job description had been originally drawn up and only 21% (120 out of 560) felt that their job description reflected their current role well. In a paper published from this same study, Scholes et al. (1999) note that the maturation of new roles and the building of experience by practitioners can mean that a preference develops for guidelines that can accommodate professional judgement as opposed to protocols which can constrain practice. Read et al. recommend that there is a need to keep the development and management of new roles under review, because of this tendency for the 'organic' development of new roles.

In their study described earlier, Roe et al. (2001) also found that practitioners in new roles described a 'dynamic nature' to the role and cited role shifts by a general practitioner who had been working more closely with nurses. No other examples of changes over time were cited.

None of the other studies examined or reported on the progress of new roles over time. The small amount of work that has been done suggests that roles which transcend traditional boundaries do shift over time and that new issues emerge because of this. All of this work is from studies looking at registered practitioners or their equivalent. The lack of work in this area implies a general view that new roles are 'static' and therefore do not need studying over time. More work is needed here.

3.4.3 Wider contextual factors that influence new roles
As would be expected, there is a range of different approaches to the analysis of contextual factors that influence new roles. Most of the studies draw on the relevant policy background as introductory material to the research, but this policy background is rarely returned to in the analysis of the findings. Some studies

identify contextual factors that stimulate the development of new roles or inhibit developments, but these findings are not usually related back to a wider context.

Nurse executive directors interviewed in Read et al's (1999) study cited a range of stimuli to the development of new roles in their organisations. Some new roles were created because of difficulties in the recruitment and retention of staff. These difficulties led to the need to manage the workforce more creatively and to retain experienced staff, and this resulted in the development of new roles. Some new roles were developed because they were desired by medical staff or in response to government initiatives, some of which recommended new roles. Other government initiatives had more general targets such as reducing waiting lists or junior doctors' hours, and achieving these targets stimulated the creation of new roles. The local purchasers of health care were also an important influence and the direction they gave to local service provision could either support or inhibit the development of new roles. Similarly, Trust budgets were generally described as being so tight that external sources of funding were often needed to develop new posts. These could include national or local charities and private companies.

Other stimuli to new role development are cited such as the local nursing strategy, the personal characteristics of individual nurses and the new opportunities presented by *The Scope of Professional Practice* (UKCC 1992). The need for quality and improvements in patient care were commonly cited as important reasons for new role development, but other remarks suggested that this was just part of the picture and that issues such as funding were also key. From their database of 838 new roles, Read et al. (1999) found that 50% (304 out of 603) of new nursing roles were cited as being developed because of a need for service development, while 10 % (62 out of 603) were developed because of policy or purchaser demand. In addition, 62% (145 out of 235) of new PAMs roles were cited as being developed because of a need for service development, while 6% (15 out of 145) were developed because of policy or purchaser demand.

Read et al. (1999) succeed in relating their findings back to the wider context and highlight the future importance of professional identity, occupational closure, approaches to educational and career development, and uniprofessional approaches to accreditation and regulation in influencing the development of new roles. This analysis is the most current and pertinent based on empirical work of new roles in

health care practice but, as discussed further below, there is a deeper level of analysis that could usefully be considered.

Two studies identify factors inhibiting the development of new roles and these include hierarchical management structures, delays in decisions, availability of resources and poor staffing levels (Roe, Walsh, & Huntington 2001; Woods 1998). Roe et al. usefully consider the shortfall in current policy that their findings highlight, but Woods' findings are largely devoid of a policy context.

No studies were identified that explored the contextual factors impacting on new roles held by non-registered workers.

Generally, these studies, and those on care co-ordinator roles and generic roles are decontextualised from the wider socio-political context. This means a lack of consideration of socio-political features that shape the organisational environment, the approach and response to innovations in organisations, the management style, the role that professional organisations and government agencies play, and ultimately how and why new roles develop.

The concept of managerialism is one example of an approach that enables analysis of this wider socio-political context. A wider context has been used to frame the empirical work of other studies in health care (for example, Ferlie et al. 1997; Fitzgerald et al. 2002), and has been used in historical analyses of health care (Bolton 2000; Killigrew 2000; Malin 2000). It has also been used to look at new roles in social care (Lymbery 2000; May & Buck 2000) but, from the evidence considered here, has traditionally not been used in studies which look specifically at new roles in health care practice.

3.4.4   Summary of the literature relating to other related new roles

There are important issues of accountability and regulation in new roles that transcend traditional boundaries that are unresolved at a national level. No work has been conducted that looks directly at what the issues are in practice for individuals without a registered qualification or equivalent, though there are indications that the picture is even more complex for these types of practitioners. The need for training prior to uptake of a new role and for a continuing approach to education in new roles is clear. This is reinforced by findings that indicate that new roles change over time, but again, more work is needed here. Finally, study

findings are often decontextualised from their wider socio-political context, and this limits wider understandings of the influences that shape new roles. Most of this work has been conducted on practitioners who hold a registered qualification or equivalent, and the valuable insight these studies give into what issues arise when traditional boundaries are transcended, indicate that the study of practitioners without such qualifications would be of great value.

3.5 Conclusions from the literature review

The aim of this review was to identify the evidence base for the IPCC role. As the first part of the review has illustrated, there are a number of methodological weaknesses and gaps in the body of knowledge with regard to care co-ordinator roles. In addition, none of the roles reviewed describe flexibility as a feature, although transcending usual boundaries and changes over time imply that flexibility is a feature of such roles. Given the prominence given to flexible working in current health service policy, and the need for clear role boundaries emphasised by some findings, it is important to understand more about how flexible roles such as the IPCC role operate in practice and what issues arise.

The review found that there is very little evidence on care co-ordinator roles held by individuals without a registered qualification in health or social care. Findings also reflect a lack of consensus as to what the care co-ordinator role is between the studies that makes the accumulation of an evidence base problematic, and a range of interpretations about what constitutes administrative work and what does not, makes distinguishing who should perform what aspects of work problematic.

The evidence base for the effectiveness of care co-ordinator roles is weak, although it suggests that there can be positive benefits to the role. However, the range of interpretations to the care co-ordinator role alone plus the plethora of other new roles emerging in health care make questions of effectiveness premature and less important than what can be learned from these roles in practice. As Pawson and Tilley (1997) vividly illustrate, it has become axiomatic in the current stage of evaluation research that 'everything, but everything, needs evaluating' (p. 1). Given that, in this study, the IPCCs were already in post before any kind of evaluation began, and that they were in post for two years before any follow-up work to the pilot work was funded, there is a pragmatic opportunity to ask

different, and possibly more useful questions, than whether IPCCs in this Trust make a difference to conventional patient outcomes such as length of hospital stay.

The more qualitative approaches in the studies reviewed were successful in pointing towards a host of issues to do with roles that transcend traditional boundaries in health care practice. However, the small scale of these studies reduces confidence in the findings and none of these studies take a longitudinal approach that enables a view of how these issues develop over time. There is a lack of evidence of the contextual influences on role development, and discussions of study findings are commonly atheoretical. There is also little known about what happens *in practice* when such roles are filled by individuals without a nationally registered qualification in health care.

The second and third parts of the literature review focused on generic and other new roles that transcend traditional boundaries with a view to exploring the issues and influences that may relate to care co-ordinator roles held by non-registered workers. These parts of the review again highlighted that little is known about such roles when they are held by non-registered workers. The evidence to date indicates that registered workers in new roles that transcend traditional boundaries encounter a range of issues including new educational need and complexities of accountability. There is some evidence that issues shift over time, and that they are even more complex for non-registered workers. A range of factors has been identified that have prompted the development of new roles held by registered workers, but no evidence was identified on the contextual influences on new roles held by on-registered workers. In general, this part of the review found very little study of generic or other new roles in practice that are held by non-registered workers.

Given the findings of this review, these are the gaps in knowledge that this study seeks to address:

1. It is not known what the issues are when a care co-ordinator role is filled by someone without a nationally registered qualification in health care. The available evidence suggests that issues may include skills and knowledge shortfall, boundary overlap, role confusion, and unclear accountability and regulation.

2. It is not known how the feature of flexibility impacts on such roles.

3. There is not a picture of what happens to these roles over time.

4. It is not known what contextual factors that influence the development of these roles and shape their progress

Current health service policy encourages the active development of roles like the IPCC role that transcend traditional boundaries, and also encourages a flexibility in how the workforce is used that has led to the development of new roles held by non-registered workers. However, as the above review shows, very little research has been conducted on new roles held by non-registered workers. The published research has highlighted some important issues for registered workers taking on new roles and indicated that there may be important issues for non-registered workers. It is therefore imperative to look at what happens when non-registered workers take on new roles.

Too often the study of specific new roles such as the care co-ordinator studies are characterised by short-term and small-scale studies that lack the necessary depth in their contributions to understanding the reality of practice. What would be of value here is an approach to the evaluation of these roles based on in-depth analyses of actual practice over time. By taking an action research approach, the present study attempts to explore, in a more meaningful way, the issues arising from and influences on the IPCC role.

4 Methods

This study used an action research approach to explore the issues arising from the development of the new role of IPCC. Action research is part of a new participatory paradigm of research. This chapter begins with an explanation of the participatory paradigm along with an introduction to action research. Details are then given of methods used for data collection and analysis, action research cycles, assessment of the quality of the research and ethical considerations of the study.

4.1   Participatory paradigm

As recognition has grown of the close relationship between knowledge and other social structures and processes, traditional methods for the production of scientific knowledge have come under closer scrutiny. No longer are the researcher and the research methods employed seen as objective and independent of the world they are researching. Rather, it is increasingly recognised that the questions asked, the researchers employed and the methods used are reflective of and a part of the social and cultural conditions that shape the phenomena under scrutiny.

Gibbons et al. (1994) have identified the emergence of a new form of knowledge production which they called Mode 2. Mode 1 knowledge production is largely based in academic institutions, is unidisciplinary and what counts as significant research problems is determined by traditional cognitive and social norms. In contrast, Mode 2 knowledge production is characterised by knowledge that is produced in the context of its application (and therefore of potentially greater utility to practitioners), by transdisciplinarity through which various stakeholders reach a consensus as to the path of the inquiry and by a diversity of skills and experience brought to the enterprise. Such knowledge production is not just university-based and privileges the notions of social accountability in research. It encourages reflexivity and uses forms of quality monitoring more diverse than the

traditional peer-review processes. The participatory paradigm represents one approach to Mode 2 knowledge production.

The participatory paradigm focuses on a concern for doing research that is *with*, *for* and *by* people and communities, rather than *on* them (Reason & Bradbury 2001). It redefines the relationship between the researcher and the researched, treating all those involved in the endeavour as equal partners. The primary aim of inquiry is to develop 'genuinely well-informed action in real-time social life' (Reason & Torbert 2001, p. 5).

The paradigm is based on an epistemology that acknowledges that there is a real world 'out there' but also recognises that attempts to describe, measure or change this reality are mediated through a range of factors including language and cultural expression (Heron 1996; Heron & Reason 1997; Reason & Bradbury 2001). This viewpoint has been described elsewhere as subtle realism and accepts that it is not possible to remove oneself from the social world in order to study it and that the goal of inquiry is to represent rather than reproduce reality (Hammersley 1992; Murphy et al. 1998; Murphy 2001). Subtle realism claims that phenomena are independent of the researcher's claims about them and accepts the possibility of 'multiple, non-competing, valid descriptions and explanations of the same phenomenon' (Murphy et al. 1998, p. 69). The use of subtle realism requires reflexivity in inquiry so that all aspects of the process of inquiry, including the role and actions of the investigator(s) are equally scrutinised (Heron 1996).

Other forms of inquiry may also hold a commitment to social action, but in the participatory paradigm it is the primacy of action that is characteristic (Heron & Reason 1997; Selener 1997). In addition, participatory forms of inquiry are distinguishable by the particularly egalitarian relationships between the researcher and the researched, and by the level, intensity and duration of the commitment to a community by a researcher (Lincoln 2001). It is the quality of relationships between inquiry participants that enriches the findings of the inquiry and optimises their utility in informing positive, practical changes (Heron & Reason 1997). As Heron (1996) writes 'in meeting people, there is the possibility of reciprocal participative knowing, and unless this is truly mutual, we don't properly know the other' (p. 11). In other words, the more steeped in the setting any external researcher is, and/or the closer the relationships between participants, the more

likely it is that deeper understandings emerge and that positive action will result. It is by transcending traditional distinctions between research subject and object that knowledge is generated (Bradbury & Lichtenstein 2000). An external researcher, by being in the setting of study, by working alongside people in the setting, and by working with them to change things for the better, is more likely to be able to reflect back the reality of the setting than one who is not so engaged (Heron 1996). In this way, inquiry in the participatory paradigm contributes to a richer picture.

The participatory paradigm incorporates many different forms of inquiry including action research, co-operative inquiry, action science, action inquiry and appreciative inquiry (Heron & Reason 1997). In this thesis, action research has been used.

4.2   Action research

Action research is 'the study of a social situation carried out by those involved in that situation in order to improve both their practice and the quality of their understanding' (Winter & Munn-Giddings 2001, p. 8). It is concerned with the generation of new knowledge through the systematic study of the process and outcomes of attempts to change and improve practice. Its main features are:

- its participatory nature (whereby researchers and practitioners work together in directing the course of change and the accompanying research)

- its democratic impulse (whereby participants are seen as equals in the process and are empowered to change the contexts in which they work together)

- its contribution to social science and social change (of knowledge which, it is argued, is of a different kind that is more meaningful to practice) (Bridges et al. 2001; Carr & Kemmis 1986; Coghlan & Brannick 2001; Greenwood & Levin 1998; Meyer 1999).

Action research uses a cyclical approach, whereby findings are fed back to practitioners as they are generated, and are then used to inform further action and data collection (Coghlan & Brannick 2001; Hart & Bond 1995). Initial action research cycles of this kind then lead on to further action research cycles. The course of events and inquiry can be unpredictable and is rarely possible to predict in advance.

Action research has been used extensively in a wide range of fields including health care, education, community development and organisational change (Meyer 2001a). It is perhaps unsurprising therefore that there is no one agreed way of doing action research. Hart and Bond (1995) have devised a typology for action research that attempts to cover and categorise the range of approaches to action research. They distinguish four main types of action research: experimental, organizational, professionalising and empowering. The experimental type reflects a scientific approach to social problems and is best characterised by Lewin's change experiments and his concerns to inform policy-making by discovering general laws of social life (Lewin 1946). The organisational type reflects the use of action research to solve organisational problems, such as low output and absenteeism. This type is primarily concerned with overcoming resistance to change and developing productive working relationships. The professionalising type is informed by a practice-based agenda and reflects the aspirations of professions such as nursing and teaching to enhance their status and develop research-based practice. The empowering type is closely associated with work in community developments and is characterised by strategies to fight oppression in working with vulnerable groups (Hart & Bond 1995).

Hart and Bond (1995) set out seven distinguishing criteria for each of the four types of action research. These criteria are educative base, individuals in groups, problem focus, change intervention, improvement and involvement, cyclic processes and research relationship. For each of these criteria, this study most closely matches a professionalising type of action research. In terms of educative base, reflective techniques by practitioners were an important strategy that was used in all stages of inquiry, including data collection. Practitioners used the study findings to reflect on their role and their contribution to patient care in the context of the interprofessional team. The response to findings was not 'What training do we need?' but, instead 'What can we learn from this that may guide our practice towards improvements?'. The interprofessional context to the work matches with the professionalising type on the criterion for 'individuals in groups'.

The use of a professionalising type of action research in this study is further reflected by a problem focus, change intervention and orientation to improvement that were practitioner (rather than service user) derived and led. In terms of cyclic

processes, cycles of diagnosis, planning, action and evaluation in this study were dynamic and opportunistic. Finally, the research relationship between the lead investigator (myself) and other participants was a collaborative relationship, based in part on the insider knowledge derived from my previous professional experiences.

In summary, a professionalising type of action research has been used as the methodological approach to this study. This is an example of inquiry in the participatory paradigm.

4.3   Research aim and questions

The aim of this study was to explore the issues arising from the development of a new flexible role in an acute medical in-patient setting, held by practitioners without a nationally registered qualification in health or social care. The study objectives were:

1. To describe the characteristics of the IPCC role

2. To explore the impact of the IPCC role on interprofessional working and patient care

3. To highlight the issues arising from the operationalisation of the IPCC role

4. To identify the key contextual influences that shaped the IPCC role.

Data collection took place between October 1998 and July 2000.

4.4   Participants

The study took place in an acute Medical and Emergency Directorate (MED) in Barts and The London NHS Trust[13]. The Trust serves an ethnically diverse population with high levels of poverty. MED includes six general medical in-patient wards that contain 153 beds between them. These six wards had input from a number of groups of staff. These included nurses, doctors, IPCCs, social workers, physiotherapists, occupational therapists, speech and language therapists, dieticians, pharmacists, ward clerks and a fast response team[14]. With the aim of

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[13] As stated earlier, Trust participants wish the Trust to be named in this work and in publications associated with it.
[14] The fast response team is a multidisciplinary team set up for directorate bed management and to focus on patients whose admission is likely to be less than 72 hours long. It includes nurses, social workers and occupational therapists.

achieving participation in line with the principles of action research, staff members from every staff group in MED were involved in the study. Data were gathered from the following staff:

IPCCs (n=4)
Operations managers (n=3)
Ward nurses (n=14)
Social workers (n=13)
Doctors (n=7)
Dieticians (n=6)
Occupational therapists (n=5)
Speech and language therapists (n=3)
Physiotherapists (n=3)
Ward clerks (n=3)
Fast response team (n=2, 1 nurse, 1 social worker)
Pharmacist (n=1)
Citizen's Advice Bureau adviser (n=1)
Clinical support nurse (n=1)
Directorate head of nursing (n=1)
Trust director of therapies (n=1)
Service lead nurse (n=1)

It was not feasible to include all members of every professional group and so representatives were selected (with the exception of the IPCCs who were all involved). Representatives of these groups were sometimes recommended by steering group members (see below) or by their departmental heads. At other times, participants were self-selected by responding to a notice circulated which invited participation. It is sometimes easier for a more senior member of staff to leave their clinical setting to attend other events and, because of this, senior staff may have been over-represented in this group of study participants.

Many more staff than those formally involved in data collection were involved in the change work arising from the study. Some of the attempted changes were directorate-wide, and so all staff were potentially affected.

All but 14 of the 69 staff listed above were women. This predominance of women in the health care workforce is reflected locally and nationally and is explained, at least in part, by the predominance of females in nursing, the largest profession (Health Care National Training Organisation 2001 cited by Sausman 2004). The

large majority of practitioners held a professional health or social care qualification and were aged in their twenties or early thirties. The exception to this was the IPCCs and the ward clerks. Sixty-three of the 69 staff were white and this was broadly representative of the qualified staff group as a whole. Staff groups in the directorate without qualifications, for example, health care assistants, tended to have a broader ethnic mix that was more representative of the local population served by the Trust. All four IPCCs were white women without formal health or social care qualifications and their ages at the outset of the study ranged from 41 to 53 years old.

4.5 Establishing the lead investigator role

Before my arrival at the Trust, managers and staff had identified the need for the project and the study had already received approval from the local research ethics committee. Ownership by participants is key to the success of action research and the involvement by participants in the early development of the study was essential. The early involvement of senior personnel such as the MED clinical director and operations managers was also crucial. These senior individuals acted as 'gatekeepers' to the organisation (Hammersley & Atkinson 1995) and were able to 'open doors' for me and help me in establishing initial contacts with other potential participants. However, once access had been established, these individuals allowed me to explore freely, and did not attempt to establish surveillance or control over my activities (which can happen when gatekeepers wish to protect their own interests) (Hammersley & Atkinson 1995).

In order to gain full access and encourage the participation of 'grass-roots' practitioners, particularly the IPCCs, I needed to establish trust and ownership. Early meetings with individuals centred on gathering information from them about their work and the context in which that work took place. I was also keen to introduce myself, and start building a rapport with potential participants. Hammersley and Atkinson (1995) note that people are often more concerned with what kind of person the researcher is than the research itself. I explained my background to people, which helped them 'place' me as a hospital nurse with research and development experience. Although I had not worked in the participating Trust before, my nursing experience in acute care meant that, from the outset, I shared a similar frame of reference to the other participants. Although it

was a new organisation to me, my experience in other organisations (about 25 other acute NHS Trusts) had taught me what aspects of NHS culture I could expect to find. Although the assumptions I held might have closed off valuable lines of questioning to me (e.g. 'Why do nurses work like that?'), they also enabled me to establish an immediate rapport with other participants, and to have a broad feel for what may be valuable initial lines of enquiry. My sociable manner and good listening skills also played a part in these early interactions (and subsequently).

I explained to staff that I was there to conduct a study which aimed above all to provide information that would be helpful to staff working in the Trust and which focused on exploring what lessons could be learned from introducing the IPCC role. I invited opinion on what might be useful avenues for exploration, and explored with individuals what role they might wish to play in the study. These interactions were well received by individuals and, following on from these, early data collection was able to commence.

As noted above (p. 5), an ethical code of practice had already been agreed with the local research ethics committee. This included gaining informed consent from participants prior to their involvement, and the use of a number of measures to protect confidentiality and anonymity of participants. As Meyer (2001b) notes, in action research it is not possible to gain fully informed consent at the outset of the study, as the flexible design means that all data collection activities cannot be anticipated. However, the democratic approach of action research means that consent must be continually re-negotiated. As the project progressed, and new avenues for data collection were taken up, information was provided to individuals being invited to participate, with the clear understanding that there was no obligation to take part. No one refused to take part in any activity, although attendance at group events was sometimes dependent on the weight of other commitments that individuals had. In summary, although some access had already been established, I needed to work with individual potential participants in the study to help design a study that met their needs and to gain their understanding of the implications of their participation for them. Individuals were left with a free choice about whether they took part, although in practice, no one refused.

Although employed on a university contract, I had an office based in the Trust and worked hard at keeping a high profile by attending directorate meetings and

creating often daily opportunities for informal interactions with participants. This gave me an opportunity to become a 'member' of directorate staff. In addition to formal data collection opportunities, I was able to access a great deal of other information, and some staff also came to use me as a resource on other matters of practice development and research. These working relationships were key to people's involvement in the project and reflect the aim of inquiry in the participatory paradigm to enrich inquiry findings through the quality of relationships between participants.

As well as research skills, I needed a range of skills in order to promote participation, democracy and positive change. Most important were my interpersonal skills and ability to reflect. I adopted a strategy of viewing people with 'unconditional positive regard' (Rogers 1957, p. 96) in the belief that this would enable individuals to feel safe in contributing more fully to the project. I tried to stay open to comment and criticism by other participants and used emerging issues and tensions as material for reflection by myself and with others. Using the principles of reflexivity (analysing the judgements I made to determine the influence of prior assumptions, feelings and experiences) and dialectics (awareness and analysis of context, changes and, in particular, contradictions between data, in understanding, between professional groups, etc.), and encouraging their use in others were also strategies employed (Winter 1989; Winter & Munn-Giddings 2001). Also important were my problem-solving abilities and skills in anticipating and handling the anxiety that people sometimes felt about feedback about their work role (Heron & Reason 2001).

As well as the opportunity to reflect with participants, I also had two other means of reflection. I met regularly with my supervisor to discuss the progress of the project and to reflect on the dynamics occurring between myself and other participants, and within the study setting generally. From January 2000, I also joined an action learning set with other action researchers. This action learning set was set up in line with the principles set out by McGill and Beatty (1992) and Brockbank and McGill (1998) and provided me with an additional and different opportunity to explore the dynamics of the action research process in my study.

4.6   Participative processes

Given that inquiry in the participatory paradigm blurs the boundaries between the researcher and the researched, it is important to outline the role that different individuals and groups played in the study.

I was the lead investigator for the study although, as indicated above, the participatory approach meant that others were also involved in the research endeavour. Trust staff contributed to the research in a variety of ways and this is described more below. Five other researchers from City University were also involved in data collection and analysis at various points in the study. My role as lead investigator included the following:

- Co-ordinating the work of other researchers involved
- Collecting and analysing data
- Feeding back findings to the directorate
- Initiating and co-ordinating development workshops
- Reflecting on progress
- Prompting 'next steps' from participants
- Supporting change work agreed

Because of the genuinely busy working lives of Trust staff, I had the main responsibility for carrying out the research and leading changes.   In practice, this often meant making decisions and then seeking the approval of key participants to carry out that decision. Attempts to include participants in the inquiry processes were mainly focused on communication about project progress and findings, negotiating the involvement of Trust staff representing all relevant professional groups and then supporting their involvement by, for example, scheduling meetings at less busy times, gaining management support for staff involvement in the project, providing a variety of means for staff to contribute to the project and providing relevant training in research methods and data collection when this was required.

Although the need for change was initiated by participant reflections on the study findings, many of the ideas for what changes could be tried came from me. These ideas were based on what I had learned about the IPCC role and the organisational context, and my experience in development work in other Trusts. Often I also carried out the work associated with making the change happen. I had no formal

power in the Trust (I was employed instead by the university) but my field notes reflect that participants often listened actively to my suggestions and usually adopted them. It is possible that my credibility as a nurse with development experience meant that people viewed my suggestions as valid. It is also likely that my in-depth knowledge of that particular context, based on data gathered also helped. Interpersonal skills may also have played a key role here, and interview and focus group transcripts reflect that my role was a facilitative one, rather than an authoritative role. As the study progressed, the length of time I was at the Trust may also have helped establish my credibility.

4.6.1 Involvement of the IPCCs

A sensitive and flexible approach was particularly needed to ensure the democratic participation of the IPCCs. They and their managers were the key people with whom study findings were shared and decisions made as to what changes could be made and/or what data were to be collected and/or shared on the basis of emerging findings. Collaborative mechanisms included formal meetings, informal contacts and the sharing of written work when it was produced. Throughout the study, I met regularly (about every two weeks) with the IPCCs. Sometimes it was just the five of us. At other times, their manager was also included. These meetings were used as an opportunity to keep each other informed about study progress and raise any issues that had emerged, either to do with the study or to do with wider changes that may be affecting the IPCCs' working role or their role in the study.

Efforts were made to take their busy work lives into account by, for example, scheduling meetings at times that suited them but there was an extent to which their involvement in the study added to their already large workloads. This sometimes had an impact on the quality of their involvement. For example, the IPCCs were asked to complete a form on each of the patients they had contact with (see patient profile below). When they were at their busiest, particularly if one of them was sick or on annual leave and the others were covering their work, the completion of these forms was not a priority. This meant that some forms were not filled in and this then compromised the validity of the data analysed. Although, perhaps understandably, the IPCCs were not always able to complete data collection, overall the IPCCs were fully involved in both the inquiry and the practice

development aspects of the study. Other issues regarding the IPCCs' involvement in the study are discussed in the section below on ethical considerations.

4.6.2   Steering group

A steering group oversaw the project during its initial exploration phase (see p. 4 for details of the study's three phases). The role of the group was as the main forum for the receipt of emerging findings and to decide on next lines of inquiry and practice developments needed. Members were encouraged to share findings with their own professional groups and use them as the basis for further discussion. Senior representatives of IPCCs' interprofessional colleagues were members of the study's steering group that ran for the first year of the project. They were selected for their seniority and ability to provide an overview. Members included the clinical director, the two operations managers, the head of nursing, the senior nurse, a social services team leader, the Trust director of therapy services and all four IPCCs. The Trust's R&D manager was also a member of the steering group.

The IPCCs rarely attended steering group meetings and it became necessary to meet with them outside of meetings to ensure that they were also aware of emerging findings and that they contributed to the direction of inquiry and practice development. Steering group members who attended were relatively senior in their position and this may have meant that initial investigations directed by the group were informed by their experiences, rather than those of 'grass-roots' practitioners who worked directly with the IPCCs. However, grass-roots practitioners were interviewed early on in the study and these findings were fed back to the steering group and used as the basis for further inquiry.

At the close of the initial exploration phase, the steering group stopped meeting and interprofessional development workshops (see p. 9 for details) became the main fora in which findings were shared and decisions were taken.   This change allowed for wider participation at all levels in directing the course of the inquiry.

4.7   Data collection and action research cycles

This section concentrates on the data gathered to generate findings and the action research cycles through which innovations were managed and evaluated. An eclectic approach was taken to data collection including the collection of quantitative and qualitative data from a variety of sources. Most data collected

were qualitative and this matches the exploratory nature of the inquiry reflected by the research questions. This multi-method approach ensures that different perspectives on the same issue can be explicated and works to minimise the impact of limitations of any one method. For ease of explanation, the main study can be divided into three different phases of data collection. The tools used in relation to each stage are listed in Figure 4.1 below:

Figure 4.1 Phases of data collection

Exploration phase - Describing the IPCC role and uncovering the issues

- Participant observer field notes (n=61)
- Interviews (n=33)
- Focus groups (n=4) (labelled A-D[15])
- Analysis of IPCC job description and relevant Trust policies (n=83)
- Patient profile (n=407)

Action phase - Monitoring the action research cycles

- Participant observer field notes (n=37)
- Focus groups (n=10) (labelled E-M in workshops 1 & 2[16])

Reflection phase – Reviewing and reflecting on the study

- Participant observer field notes (n=12)
- Focus groups (n=2) (labelled N-P[17])
- Interviews (n=4)

In practice, the differences between the three phases were not as discrete as they appear. For instance, the exploration phase lasted throughout the study as findings from other phases highlighted further data collection needed to illuminate the IPCC role. Data gathered from monitoring action research cycles also added to understanding of the role. In action research, data collection needs to be responsive to emerging findings and practice changes, and this can mean that several activities can take place at once, or that data collection takes place in anything but a linear manner. However, three phases are used here to ease explanation.

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[15] See Appendix 3, p. 10
[16] See Appendix 3, p. 10
[17] See Appendix 3, p. 10

4.7.1 Exploration phase

This stage consisted of collecting data aimed at describing the characteristics of the IPCC role, the impact of the role on interprofessional working, and the issues and problems associated with the role. A number of different data sources were used to describe the role and these are now described in greater detail.

4.7.1.1 Participant observer field notes

Detail has already been given of my different activities in the practice setting. Other activities were also undertaken with the primary aim of collecting data. I documented field notes in both types of interactions, that is, when the primary aim was to collect data and when the primary aim was another activity, for example, development work. There was a range of activities in which data collection was my primary aim. For instance, I often attended and observed the IPCCs' weekly meeting with their manager. I attended some weekly interprofessional meetings (n=9) over the course of 12 months to observe the IPCC role within that setting. I attended four of the monthly directorate management meetings. I had frequent, unplanned contact with study participants where I would 'bump into' someone in the practice setting and exchange information with them. I also shadowed each of the four IPCCs in practice over 24 half-day sessions. One IPCC was observed for seven sessions, two IPCCs for six sessions each and one IPCC for five sessions.

Although the primary aim was to collect data in each of these activities, my relationships with other participants and my role in the wider project often meant that I engaged in interactions with those present and sometimes helped out by, for example, answering the phone in the IPCC office when things were busy. Another example of this interaction is, during the shadowing of an IPCC, if I observed something that I did not understand, I would discuss the issue with the IPCC during the period of observation (but not usually during the event in question). Gold (1958 cited by Hammersley & Atkinson 1995) identifies four distinctive field roles: the complete participant, the participant as observer, the observer as participant and the complete observer. The complete participant conceals their true identity from those being observed, while at the other end of the spectrum, the complete observer has no contact at all with subjects. The degree of participation distinguishes the other two roles of participant as observer and observer as participant, although Hammersley and Atkinson dispute that there is value to be gained from

distinguishing between these two roles. My role in this study overall most closely matched that of participant as observer in Gold's typology, whereby I created a role for myself within the group and participated as a member of that group in developing practice. Alongside this, I made observations of the setting and the people and activities within it. However, as will be discussed below, this may not be a helpful distinction to make.

Gerrish (1997) notes the tensions that nurse researchers can experience between the roles of participant and observer when, for example, she felt emotional discomfort at what she was participating in with the district nurses she was working with, but as a researcher, felt she could not express that discomfort. I found that while action research enabled a closer integration between the two roles of participant and observer (because, for example, of the dual purpose behind many development activities), I still sometimes experienced dissonance during activities when data collection was the primary aim. For example, in shadowing one of the IPCCs, I observed her raise the prospect of nursing home placement with a patient who had not yet been assessed by a social worker or qualified health professional. As a nurse, this shocked me and, had I been a nurse with a clinical role, I would have stepped in and attempted to rectify the situation. Usually, because of the major implications such a move would have for an individual, such a discussion would only have been had with a patient after formal assessments by a social worker and qualified health care staff, and would have been initiated by someone with a formal training in handling such sensitive matters. However, in my role that day as a researcher observing how this IPCC worked in practice, I felt I should not intervene, as I would not then have seen how that patient interaction ended without my interference. The patient was also not physically at risk and this was an important consideration in my decision not to intervene. However, this inability to act made me feel very uncomfortable, and represented the tensions between my background and values as a nurse and my role as an observer.

More recent writings on the role of observation (particularly in ethnographic studies) have moved away from the challenge raised by Hammersley and Atkinson (1995) of being a 'marginal native', that is to maintain a marginal position in the field that enables access to participants but minimises 'the dangers of over-rapport' (p.112). In contrast, Angrosino and Mays de Pérez (2000) dispute that a distance

between observer and observed is possible or desirable, and call for a perspective that uses observation as a 'context for interaction' between participants in a collaborative inquiry (p.676).   In other words, the interaction itself between 'researcher' and 'researched' becomes the focus for inquiry.

To return to the example above of the IPCC discussing nursing home placement with a patient, reflecting on this incident with the IPCCs and their colleagues illuminated some of the tensions that are experienced between qualified health and social care professionals and IPCCs because of the IPCCs' lack of formal training for their work with patients. If I were not a qualified nurse, I may not have realised the significance of what I was observing, and this is an example of how my individual characteristics framed my observations. Because it was an action research study, I was able to use the incident as a case for reflection with participants and this helped provide contextual meaning to the observation. It may be, given this and other similar experiences throughout the study, that within an action research context attempting a distinction between participant and observer is not time well spent. The challenge is in identifying what can be learned from what is observed in practice and from how that information is then used.

I recorded my observations and reflections in writing, sometimes at the time the events were happening and sometimes later that day. These records were kept of activities where data collection was the primary purpose and of my wider activities in the project, for example, meetings with the key participants.

These field notes served to record events occurring on a day-to-day basis within the study and those events external to the study that either influenced study progress or the work of the IPCCs. The field notes included my own record of meetings attended and accounts of informal discussions. In this phase, field note entries (n=61) were recorded for the following activities:

- Observations of IPCC work (n=24 half-day sessions)

- Observations of weekly meetings between IPCCs and their manager (n=13 meetings)

- Observations of weekly interprofessional meetings (n=9 meetings)

- Records of meetings with participants (n=4 meetings)

- Records of informal interactions with participants (n=3 interactions)

- Letter to participant (n=1 letter)

- Records of steering group meetings (n=3 meetings)

- Reports/preliminary data analyses (n=4)

The field notes were thus often descriptive of what I had seen and what I had heard, with interpretations and reflections added. The field notes also included preliminary data analyses carried out as data became available. As Emerson et al. (2001) point out, field notes are a representation of events, persons and places, and a degree of selectivity by the researcher is therefore an unavoidable feature. Emerson et al. note that field notes cannot provide a complete record because of decisions made by the researcher about what is significant enough to record, what can be left out and how observations are framed. These decisions may not always be conscious, and it is therefore important that the researcher is reflexive about the processes of observation and recording field notes. I tried to be reflexive about the decisions I was taking, and the account given here gives some detail about what was included. I made a conscious decision not to record things that people told me that I judged would make them uncomfortable if they were repeated to anyone else, for example, personal details about themselves or someone else that, in my opinion, were unrelated to the study focus.

Where data collection was a primary activity, the consent of those being observed was explicitly sought prior to the observation commencing. The aims behind the observation were explained and individuals were advised that they could halt the observation at any time. In contrast, it was not practical to obtain consent from people for me to 'observe' them in activities where development was the primary aim or in encounters that were more informal. The aims of the project had been communicated across the directorate by managers and staff were already aware of my activities. The high profile of the project, plus the familiar presence I established for myself, obviated the need to regain consent at every encounter.

While seeking consent, I negotiated with participants how I might best achieve anonymity of their contributions when findings were reported back. The challenge here was that findings would be reported back locally and far earlier than in other types of research studies, thus leaving participants vulnerable to identification. I

negotiated that names would not be used in reporting (codes were always assigned instead of names in written records) and that findings would be reported in such a way that it would be hard to identify who had said or done something. For example, it was agreed with the IPCCs that if a report contained their biographical details, these would not include their individual codes (or names). These codes could then be used in another part of the report to report what individual IPCCs said or did with a reduced risk of their identification. Similarly, it was agreed with the clinical director that her words or actions would be attributed in reports to a doctor or a manager, whichever was more relevant at the time. This would help protect her identity. However, as Meyer (2001b) notes, it is not possible to completely guarantee anonymity or confidentiality as participants may talk to others in the field, and this was explained to potential participants prior to inviting their consent. The distinctive job title of two individuals has been used alongside some of their comments in the findings chapters (chapters 5-7) and permission has been sought from these individuals for this to occur.

4.7.1.2   *Interviews*

One-to-one face-to-face interviews (n=33) were conducted with the following individuals during the exploration phase:

- 8 social workers (including fast response team social worker)

- 7 nurses (including fast response team nurse)

- 4 IPCCs

- 4 doctors

- 3 ward clerks

- 3 physiotherapists

- 2 operations managers

- 2 speech and language therapists

- 1 senior nurse

- 1 occupational therapist

- 1 dietician

People were interviewed who either worked in the IPCC role or who worked directly with the IPCCs. In a small number of interviews (n=3), two professionals from the same professional group were present. All other interviews were one-to-one. A questionnaire with open-ended questions was used to guide discussion during the interviews (see Appendix 2, p. 209). Topics covered in the questionnaire included the role and activities of the IPCC, changes in the role since it started, and advantages and disadvantage to the role. In practice, the questionnaire was used as a broad framework but participants were also encouraged to engage in 'natural' conversation and the interaction would explore lines of inquiry that came up even if they had not been anticipated for in the questionnaire. Interviewees often asked me questions which I would endeavour to answer. When the opportunity emerged through the interaction, interviews were also used as opportunities to share study findings to date, reflect on these and sometimes to plan developments or further data collection.

Interviews ranged in length from 20 minutes to one hour and usually took place in my office in the Trust or in the interviewee's office if this was at a suitable distance from their usual place of work. The reason for these chosen locations was to minimise the distractions for the interviewees (and the noise for the audio-tape recordings), although those with bleeps were often called to use the 'phone during the interview. Once the call was over, the interview was resumed. Most interviews were audio-tape-recorded, transcribed and checked. When a tape recorder was not used (usually if I had not met the interviewee before), individuals were invited to verify my typed-up notes of the interview.

More recent writing on interviewing reflects a recognition that interviewers are as much a participant in the interactions that take place as the interviewee, and interviews are increasingly being seen as 'negotiated accomplishments of both interviewers and respondents that are shaped by the contexts and situations in which they take place' (Fontana & Frey 2000, p. 663). Although the interviews in this study had some characteristics of more traditional interview methods (e.g. location of my office, pre-set interview schedule, my usually taking the lead in the 'flow' of the interview), the fact that they took place in the context of an action research study meant that, particularly for interviewees involved in other aspects of the study, power relations were different. I would argue that attempts to establish

democracy throughout the study meant that interviews were conducted as a more equal enterprise between myself and other participants. I needed to be reflexive about my role during interviews and take opportunities to negotiate the structure and content of individual interviews with interviewees. (As my relationships developed with other participants over the action and reflection phases of the study, we no longer used interview schedules but instead agreed a brief topic guide at the outset of the interview – see below). The use of interview settings to share study findings and plan further developments is supported by Fontana and Frey's (2000) recommendation to utilise feminist interview techniques that aim at more democratic and participatory rather than exploitative purposes (Oakley, 1981).

Prior to interviews taking place, potential participants would be phoned or contacted by letter to be given a brief explanation of the project and the purpose of the interview, and be invited to participate. If they agreed (and no one refused), a mutually convenient date and time would be set. At the arranged meeting, more detail would be given of the project and the interview purpose, and confidentiality and anonymity would be discussed (as above). Participants were advised of their right to halt the interview at any time, and encouraged to stray from the interview schedule when they felt it was relevant. If the interview was to be tape-recorded, participants would be informed that the tape would be transcribed and then stored in a locked cabinet. The written transcript would contain codes not names, and would also be stored in a locked location. If the individual agreed to proceed, permission would then be sought to tape record the interview or make written notes. No one refused to take part.

4.7.1.3 *Focus groups*

Four focus groups were held with the IPCCs' interprofessional team colleagues to explore understanding of the IPCC role and explore the issues pertaining to that role. One focus group was held with each of the following groups:

- Social workers (n=12 social workers present) (focus group A)

- Dieticians (n=5) (focus group B)

- Nursing ward managers (n=4) (focus group C)

- Occupational therapists (n=3) (focus group D)

Appendix Three (p. 211) gives details of each of these focus groups. As with other focus groups later in the study, each group was unique in its membership and the focus of its discussions. As Appendix Three demonstrates, groups varied in their size, membership and whether or not a questionnaire guided discussions. As with the observation and interview strategies used, the purpose of the focus groups often went beyond the mere collection of data. In some focus groups, I took a more explicit lead in asking the questions and facilitating the group by attending to group dynamics and encouraging all points of view. But in other focus groups, my role was much more 'back-seat' and consisted of allowing the interactions to develop naturally.

These differences in style were due to a number of factors including the phase of the study, whether or not those group members had been interviewed before in the study (if not, focus was more likely to be data gathering) and whether those group members had gathered together before to discuss these issues (if not, freer discussion was more likely to emerge). The action research framework enabled this responsiveness and also legitimised the shared learning and developments that resulted.

An important advantage of focus groups is their ability to enable observation of social interactions (Kitzinger 1995). Feminist researchers have also noted how the balance of power within a focus group alters in favour of participants. This helps to encourage freer expressions of ideas and validation of the experience of participants, and reduces the influence of the researcher (Madriz 2000). In the focus groups in this study where facilitation was minimal rather than directive, transcripts reflect high information exchange between participants.

The potential of focus groups for consciousness-raising and fostering social change has also been recognised (Madriz 2000), and action research is one means by which such potential could be operationalised. In focus groups carried out within an action research study, participants become more than providers of information; they can also be agents of change. Even in this exploration phase, there was evidence of action planning. For example, in focus group A between the IPCCs' manager and the social workers, the value of the discussion that ensued in a group which had not communicated before led to many ideas for continuing the communication that had begun.

At the outset of each focus group, detail was given of the overall project and the aims of the focus group were set out. Confidentiality and anonymity were discussed (as above). Participants were advised of their right to halt the group at any time, and encouraged to stray from any set questionnaire where they felt this was relevant. They were encouraged to not all speak at once and to ensure that everyone had a chance to contribute. If the focus group was to be tape-recorded, participants would be informed that the tape would be transcribed and then stored in a locked cabinet. The written transcript would contain codes not names, and would also be stored in a locked location. If the group agreed to proceed, permission would then be sought to tape record the interview or make written notes.

4.7.1.4   Analysis of Trust documentation

Documents were sought that provided information on the level of policy support for and on outcomes of the activities of the IPCCs. Information was gathered by questioning directorate managers as to the existence of relevant documents and by hand-searching the policy and procedure manuals located on the wards. Eighty-three such documents were found:

- IPCC job description (dated 1996, revised April 1999)

- Trust policy on discharge planning (January 2000)

- Directorate standards for medical staff (May 1999)

- Monthly directorate information reports on length of stay based on information extracted from patient administration system (PAS) (1995-1999)

- Monthly directorate returns on number of patients with delayed discharge (extracted from forms completed by IPCCs) (1996-1998)

These documents were read and analysed with a view to seeking written policy support for IPCC activities and an understanding of changes in the key indicators of length of stay and delayed discharge. Policy documents were also discussed with participants in the context of discussions of other study findings.

4.7.1.5   Patient profile

Early data collection suggested that individual IPCCs had developed their own methods of practice. Interview data also threw light on the types of patients most commonly seen by IPCCs, but it was recognised that this might not be the whole picture. In order to expand on these early findings, the IPCCs helped to construct a profile of all the patients they worked with over the course of a year. As this was predicted to be a large piece of work, four other researchers were drafted in over the course of a year to aid with the collation and analysis of data.

Each IPCC completed a form on every patient they had contact with, that included collection of data on the following:

- Name of IPCC

- Patient age and date of birth

- Date of admission

- Admission diagnosis

- Type of IPCC input

- Discharge/death date

- Discharge destination

The IPCCs kept these records from January 1999 to January 2000. The IPCCs updated the form throughout the patient's admission and then submitted the completed forms on discharge. A total of 814 patients were recorded. Where information was missing on the written form, details were sought from the PAS six or more weeks after discharge. To enable comparisons of IPCC patients with the whole patient group admitted to the directorate, the Trust's information services department used information initially recorded on the PAS to provide information for all directorate patients for the same time period.

Because of the volume of data gathered, only information gathered on patients admitted between 1/4/99 and 31/8/99 (n=407) was eventually used for analysis. There are three important limitations to the data gathered and used. Firstly, it is not possible to know how many patients did not have forms completed by the IPCCs. At times when the IPCCs were very busy and/or all four of them were not working

(because of leave, sickness, etc.), they were not able to complete a form on every patient they had contact with. There may also have been variations between individual IPCCs in how many forms they completed. Secondly, not all of the forms were fully filled in and it was not always possible to supplement form information with that held on the PAS. In some cases, the PAS did not hold the information required. In other cases, time constraints on the investigators meant that significant amounts of missing data could not be sought using the PAS. This led to significant amounts of missing data for some variables. Thirdly, the period selected (April to August 1999) may not be representative of the picture year-round. It may be that the winter months represent a busier time, for example, and that the findings cannot be extrapolated to other times of year.

Measures were taken to protect patient confidentiality. All researchers working on the project signed an agreement with the Trust promising to keep patient information confidential. Once the written forms had been submitted, individual patients were assigned a code. Information from the form was then entered into a File Maker Pro (version 5.0) database against the patient's code. Neither patient names nor hospital ID numbers were entered on the database. The original forms and code sheets were kept in a locked cupboard at City University. The database was password-protected, the password only being known to the researchers inputting data.

4.7.2   Action phase

During this second phase, three action research cycles took place, which included a number of different innovations. The processes and outcomes of this development work were monitored using a range of methods.

4.7.2.1   Action research cycles

An action research cycle is a process of diagnosing, planning action, taking action and evaluating action (Coghlan & Brannick 2001). In practice, the process is often not linear and activities are often so intertwined as to be indistinguishable (Hart & Bond 1995; Heron & Reason 2001). For ease of explanation, three action research cycles can be identified for this study: 'communicating about the IPCC role'; 'exploring issues of accountability'; and 'improving interprofessional working'. Detail for each of these cycles has been given in the introduction chapter (p.8).

In each of the action research cycles, practitioners agreed and defined what improvements should be made. A multi-faceted approach to change was taken, which reflected differing views of what improvements were required. In addition to the participatory processes outlined earlier, the structures and processes in which development work took place were also used as opportunities for data collection. This will be illustrated in the following discussion of data collection activities.

4.7.2.2   Participant observer field notes

Field notes were kept in this phase in the same way as has been described for the exploration phase. My field notes aimed at recording events occurring on a day-to-day basis within the study and those events external to the study that either influenced study progress or the work of the IPCCs. The field notes include my own record of meetings attended and accounts of informal discussions. They also include my reflections on progress and preliminary data analyses carried out as data became available. In this phase, field note entries (n=37) were recorded for the following activities:

- Reports/preliminary data analyses/reflections (n=13)

- Letters to participants (n=9 letters)

- Records of meetings with participants (n=8 meetings)

- Record of informal contact with participants (n=5 contacts)

- Records of interprofessional development workshops (n=2)

As is evident, there were no activities in this phase in which data collection was the primary aim. In all of these activities in the action phase, I had an active development role.

4.7.2.3   Focus groups

During the action phase, ten focus groups were held to explore the emerging issues and to use reflection on study findings to plan future action. Nine focus groups were held with interprofessional representation and one further focus group was held with representatives from each of the therapy professions working in the directorate. Details of each of these focus groups (focus groups E-M) are given in Appendix Three.

Two interprofessional development workshops were held to share study findings and plan innovations. These workshops allowed for different groupings of staff over the course of each workshop and, between them, this enabled the configuring of eight of the focus groups (focus groups E-L). Further details of these arrangements are given in Appendix Three.

In each of the two workshops, particularly in the smaller focus groups held within them, I kept a low profile beyond sharing the study findings to date. Other researchers took the lead in group facilitation and data collection. By this point in time, my profile was high in relation to the project and I wanted to do all I could to encourage ownership of the developments by the other participants.

A number of factors specific to this phase may have affected the contributions made to the focus groups. For instance, the focus groups within the interprofessional development workshops were often severely constrained for time and this meant that the facilitators kept quite rigidly to the pre-set questionnaire, although some 'straying' was permitted. In the larger groups (in which n ranged from 23 to 30[18]), discussions were freer and allowed to develop naturally, although the large group setting may have intimidated some participants into staying silent or not being completely open. While the facilitators played a part in managing group dynamics, the size of the large groups (and the constraints on time) meant that is was impossible for everyone to have an equal contribution. In the literature, ideal focus group size is generally between 6 and 12 people (Lewis 2000). The smaller focus groups (n=5-12[19]) gave everyone a chance to contribute in a smaller setting, and these groups were easier to facilitate to achieve this.

Another consideration here is the diverse membership of the groups. Participants were not always known to each other before the workshops. Everyone wore name badges and, at the outset of the small groups, people introduced themselves. However, the presence of 'strangers' may have inhibited some contributions. Equally, the profession or seniority of individual participants may have meant that some individuals were liable to dominate discussions, while others were liable to stay silent or not be completely open. Again, the facilitation of the groups will have played a part in minimising influences of this kind, and the transcripts of the

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[18] Including research staff/facilitators.
[19] Including research staff/facilitators.

small group discussions reflect that everyone contributed. In the large groups, not everyone contributed and, as noted above, time made this impossible to achieve.

In this phase, a focus group was also held with five senior therapists (focus group M). This was aimed at updating on the progress and findings of the study to date and on therapists' relationships with the IPCCs, and to discuss the proposed development work.

Much of the writing on focus groups has focused on the contribution that the technique can make from a data collection point of view. Few authors have considered the benefits to group members of taking part. Some writers on focus groups have discussed how group interactions and the perspectives of others can trigger new learning in individual group members (Kitzinger 1995; Madriz 2000). Barbour (1995) notes the potential for using focus groups in action research 'as part and parcel of the programme designed to effect change' (p. 332). It is possible in this study that the explicit use of study findings as a backdrop for discussions, along with the impact of hearing others' views and attempting to reach group consensus on defining a problem and then planning a development, also enabled new understandings to emerge. The focus groups were also used to explicitly plan action.

Briefing notes sent in advance of the focus groups mentioned that audio-tape-recording of the session was planned and objections were invited in advance. At the outset of each group, permission to tape-record was explicitly sought, and confidentiality and anonymity were discussed (see above). No one refused to take part although a small number of individuals were unable to attend the focus groups at the last minute because of urgent clinical commitments or sickness. No one objected to the tape-recording taking place.

All focus groups were audio-tape-recorded. The tape recordings were then subsequently transcribed and checked. Reports based on the transcriptions were then sent to each participant of workshop proceedings and of action plans agreed. Comments were invited on the accuracy of the reports. No adverse comments were received. In addition to the tape recordings, researchers in observer roles made their own notes on group layout and dynamics. Data were stored in the same way as in the exploration phase.

4.7.3 *Reflection phase*

In reality, reflection was ongoing throughout the study and the development work towards achieving innovations continued beyond the close of this study. However, during the closing stages of the actual study, it was useful to plan what developments needed to continue and how this might be achieved. A review was also held of what changes had occurred and what had not changed, and the reasons for these. It was also felt important to review the action research process and consider its utility to the participants. This review consisted of my reflective field notes, two focus groups and two one-to-one interviews.

4.7.3.1 *Participant observer field notes*

At the close of the study and subsequently during the sharing of final study findings with participants and more widely, I continued to keep reflective written accounts of reflections and events. Twelve field note entries are recorded for this period.

4.7.3.2 *Focus groups*

Two focus groups were held in the reflection phase. One focus group (focus group N) was held with representatives of the IPCCs and different professional groups to plan developments on interprofessional working that could be carried forward after the study had come to an end. A second focus group was held with IPCCs (focus group P) to enable them to share their reflections on the action research process and identify what changes had happened during the course of the study. Further details of each of these groups are given in Appendix Three.

The interprofessional focus group was focused particularly on action planning and this reflects how a focus group within an action research framework can be used to empower participants to achieve positive changes in their working lives. Most of the focus groups held in this study represented groupings that had not been achieved before to discuss and action plan around issues of common concern. The feedback from all of the groups was positive without exception as to their usefulness.

At the outset of each group, permission to tape-record was explicitly sought, and confidentiality and anonymity were discussed (see above). No one refused to take part. Both focus groups were audio-tape-recorded. The tape recordings were then

subsequently transcribed and checked.   Data were stored in the same way as in the exploration phase.

4.7.3.3   *Interviews*

Four interviews were held in this phase. These were with the two operations managers, the clinical director and the senior nurse.

Due to Trust-wide organisational restructuring, both operations managers left the Trust in June 1999. One-to-one, face-to-face interviews were held with each of them prior to their departure. Similar interviews were also held with the senior nurse and the clinical director at the close of the data collection period (June 2000). For each interview, a broad topic schedule was agreed at the outset and used to guide discussions (see Appendix 2, p. 209), but, as with earlier interviews, discussion was allowed to develop freely. Interviews focused on reflecting on the action research process and on changes during the course of the study in IPCC practice and in factors that influenced IPCC practice. By this stage of the project, I had developed close working relationships with each of the participants and this enabled a rich two-way discussion including the sharing of study findings. Although it could be argued that our relationship may have prevented the expression of any negative feelings, the interview transcripts reflect that these two individuals were able to express dissatisfaction with the action research process and outcomes when this was felt. I have no reason to believe issues were hidden.

Interviews were audio-tape-recorded with permission and following discussions of confidentiality and anonymity. Recordings were then transcribed and checked. Data were handled and stored as outlined above.

In summary, data were gathered from a variety of sources using a range of methods. These data were gathered with the intention of describing the IPCC role and its impact, and on exploring the process and outcomes of change. The action research approach used impacted significantly on the processes of data collection. Analyses of these data will now be described.

4.8   Data analysis

Analysis of findings was conducted throughout the data collection process, as emerging findings were reflected on for meaning and shared with participants for

their interpretation. These analyses were then used to prompt further data collection and/or changes in practice. In this sense, analysis was a joint activity between the participants, other researchers involved and myself.

After data collection had ended, a formal phase of analysis began which I mainly carried out, and it is this process that is described below. In this phase, I took regular opportunities to reflect on emerging findings with other researchers, some but not all of whom had been involved in data collection in this study. Also, written drafts of the findings were shared with the key participants, and their comments and queries were actively sought in workshops and meetings set up for this purpose. Under my direction, a second researcher assisted with the analysis of the patient profile data. This was a joint endeavour, but I had the main influence in the translation of raw data into findings. Because of this, the findings presented are therefore framed by my personal background, values and experiences.

4.8.1   *Interview, focus group and field note data*

Interview, focus group and field note data were analysed using the software package NUD*IST (Non-numerical Unstructured Data Indexing Searching and Theorizing) (V4.0). The process used within NUD*IST began with description and sorting of the data, and concluded with theorising. The stages were coding, describing, summarising, interpreting, and writing. These stages are aimed at describing the broad process, although, in reality, the work was inter-linked and interdependent, and the stages are therefore not mutually exclusive. Each stage required judgement and decision-making on my part.

Each piece of data was read and reflected on, and assigned one or more codes. The codes were developed inductively from the research questions and the data but it is also likely that my own personal framework that had built up from my in-depth knowledge of the study setting influenced the emergence of the coding framework. The framework or 'tree' that emerged represented the relationship of the different codes to each other. Each code had an assigned 'node' in the tree. The final tree contained 129 nodes. In addition, 24 free nodes were assigned which did not directly link into the tree. The final list of nodes is shown in Appendix Four (p. 225). Appendix Four also includes an excerpt from the tree to illustrate how the nodes were linked to each other. The whole tree is too large to show. The links

between nodes can also be inferred by their numbering in the list shown in Appendix Four.

Where the label for the node was not sufficient description, nodes had a description attached to enable accurate coding. As new codes were developed, it was necessary to review all the data previously categorised to see if any of it applied to the new codes. The emphasis in this stage was on descriptive codes, rather than interpretive ones.

Data within each node were then read and reflected on to ensure that each node contained data with a similar meaning. Some new nodes were developed at this stage.

Data within each node were then summarised so that the whole body of data became a more manageable size. Each piece of summarised data was given one or more 'location codes' so that it could be linked back to the original data source if this was required. During this summarising process, constants checks were made with the original data context to ensure meaning was not lost.

Summarised data in each node were then read, reflected on and re-categorised into wider themes. For example, a main theme was developed of 'What IPCCs do'. This included the main activities of:

- Moving patients through the system quickly/relieving acute pressures

- Helping/supporting interprofessional colleagues

- Knowing about patients and resources

- Ensuring appropriate care

- Ensuring appropriate discharge

- Being known

- Aiming towards discharge all the time

Each of these main activities had associated summarised data (with location codes) that provided in-depth detail of work in each of these activities. This activity of interpreting involved checking back to original data sources again to ensure that original meaning was preserved.

4.8.2 Documentary analysis

Relevant Trust policies and other documents were read and reflected on to illuminate the intentions behind setting up the IPCC role, and the existence of a formal structure to support IPCCs and wider interprofessional working.

4.8.3 Patient profile

Details were entered onto a File Maker Pro database (version 5.0). Microsoft Excel 2000 and Minitab (version 10) were used to perform a range of descriptive and comparative statistical calculations. Frequency and proportion were calculated for each variable. In addition, patient age and length of stay were described for each IPCC and for the IPCCs as a group using the following calculations: frequency, mean, median, mode, standard deviation and range. Pearson's correlation was used to explore the relationship between age and length of stay. One-way analysis of variance was used to explore differences in length of stay between the IPCCs.

4.8.4 Crystallisation of data

As analysis progressed, similarities and inconsistencies in the data raised perspectives that could be alternatively viewed using other data sources. This process of identifying, analysing and reporting multiple perspectives is known as crystallisation, rather than triangulation. Triangulation assumes there is a fixed point or object that can be triangulated or, in other words, a 'master reality' to be discovered (Richardson 2000; Murphy et al. 1998, p. 11). It can discourage the researcher from analysing the data in context and uncovering the situated work (Murphy et al. 1998).

In contrast, crystallisation reflects the concept of multiple perspectives, the view of which is dependent on one's angle of repose (Richardson 2000). Crystallisation provides us with a 'deepened, complex, thoroughly partial, understanding of the topic' (Richardson 2000, p. 934). It offers opportunities to compare contrasting findings such as differences between policy and practice. It does not deny that there is a real world out there, but recognises that attempts to measure and describe that world are influenced by a complex range of social and cultural factors. In crystallisation, the challenge is to reflect multiple perspectives, while recognising that one's account can only ever be a partial understanding of the topic. Because of

this, I needed to be reflexive throughout the research process about my own values and intentions as a researcher.

4.9   Assessment of the quality of the research

While some writers on action research suggest that the quality of an action research project can be judged solely by the action researcher using 'professional judgement' (Rolfe 1998), others assert that quality should be judged by marking the project against an externally approved 'checklist' which sets out clear standards of practice (Waterman et al. 2001). A suitable 'middle way' can be used based on the criteria of validity and relevance for qualitative inquiry proposed by Murphy et al. (1998).

A key issue is how my previous background and values may have influenced the course of the inquiry. For example, it is worthwhile to reflect on whether it was appropriate for a qualified practitioner such as myself to be investigating practitioners without formal qualifications who were taking on previously professional work. It may be that my professional background over-sensitised me to some of the tensions and issues emerging, and that there was a danger of, for example, exaggerating the importance of particular lines of inquiry, because they reflected assumptions and values of my own. I was aware of these potential issues from the outset and worked to recognise and overcome them in a number of ways. Murphy et al.'s (1998) criteria of validity and relevance provide a useful framework within which to discuss the approach used.

4.9.1   Validity

Murphy et al. (1998) identify a number of practices which can enhance the validity or truthfulness of qualitative research and provide the reader with the information needed to evaluate the trustworthiness of the findings. These practices include detailed descriptions of the processes of data collection and analysis, reflexivity on the impact of the research process and the researcher on the data, attention to negative cases and 'fair dealing' or the commitment to represent study participants even-handedly.   In addition, in action research, details should be given of how the action research process impacted on data collection and analysis. This will include the different ways participants were involved in data collection and analysis, the processes used to feed back findings and an account of how findings were

subsequently refined. These practices have been adhered to closely in this study. Detailed description has been given in this chapter on the methods used for data collection, analysis and the impact of an action research approach. These descriptions have been underlined by reflexivity particularly in relation to the role of the researcher and those of participants. Further reflections on the action research process and its impact are shared in the penultimate chapter of this thesis. Negative cases are identified and discussed in the next three chapters within discussions on study findings. Fair dealing is reflected in the multiple perspectives reported in this thesis, from those working at all levels and in all parts of the directorate.

While not an objective check of validity, member checks can usefully be used in qualitative research as a way of minimising errors and providing further data from participants' responses to the researcher's analyses (Murphy et al. 1998). Findings were shared as they emerged with participants throughout the course of the study. Participants were invited to comment openly on analyses undertaken. The aim of this was to reduce errors in understanding individual perspectives on the issues and to gather further data. One example of a formal 'member check' took place towards the end of the study. A draft of the study report for the Trust was shared with the IPCCs and the directorate managers. Meetings were then held with these individuals (the IPCCs met as a group) and their responses to the draft report were recorded. Errors that had been pointed out were corrected in the final version of the report. Where participants disagreed with what had been written, this disagreement was reflected on and incorporated into the final Trust report (and in this thesis) as additional findings.

In addition to these criteria proposed by Murphy et al. (1998) and expanded on here for the purpose of action research, catalytic authenticity is also relevant to assessing action research. Catalytic authenticity is the ability of an inquiry to prompt action on the part of participants (Lincoln & Guba 2000a) and this chapter and subsequent chapters describe the extent to which participants engaged in the need to change and made changes in their own practice. This criterion, also strongly related to relevance, is discussed next.

4.9.2 Relevance

Murphy et al. (1998) argue that relevance of a study can be viewed in terms of it being of concern to practitioners, but also argue that findings should contribute to the accumulation of knowledge in a field. The action research processes described above ensured that the issues addressed and the findings uncovered were of direct relevance to practitioners in the setting, but the issue of generalisability beyond that setting is more complex.

This study has been written up as a case study. Case studies are not usually designed with the purpose of generalisation (Hammersley & Gomm 2000; Stake 2000). It is claimed that the intrinsic worth of case studies is in the in-depth study of the particular, of that unique case (Stake 2000). The findings of a case study are valuable in themselves, regardless of their ability to generate theory that may be applied in other settings. This value is particularly important in action research studies, where the primary value of findings is their use in the context in which they were generated. Generalisation from case studies is, however, also possible and there are three ways in which this may be achieved.

Empirical generalisation is based on the claim that, because of the representativeness or typicality of the sample to the population, the findings from the sample are typical of the wider population (Sharp 1998). The greater use of statistical sampling techniques may enhance the empirical generalisability of the findings from a case study (Murphy et al. 1998) but it is not this type of generalisation that is claimed by this study.

The second type of generalisation relies on persuading the reader of the reasonableness of generalising the results, usually by providing a 'thick description' of the study setting (Lincoln & Guba 2000b; Meyer, Spilsbury, & Prieto 1999). If the writer provides sufficient descriptive detail of the context of the inquiry and its findings, the reader should be able to vicariously experience events, draw their own conclusions and judge the similarity or 'fittingness' between the study context and the reader's own practice setting (Lincoln & Guba 2000b) . In this thesis, contextual detail of the study and in-depth findings are described, and the reader is invited to judge the applicability and utility of the findings for their own practice setting.

The third type of generalisation is known as theoretical inference or analytic generalisation (Murphy et al. 1998). This relies on techniques such as analytic induction and deviant case analysis to 'systematically establish the potential for and limits to the generalisability of theoretical claims arising from and within particular settings' (Murphy et al. 1998, p. 197). This thesis illustrates the use of a single case to construct and test theories in this way (Meyer, Spilsbury, & Prieto 1999) and this is reflected by the claims made at its conclusion for the wider theoretical generalisability of the findings.

4.10 Ethical considerations

The local research ethics committee granted ethical approval for the study prior to its commencement. However, the process of the study raised a number of issues that required consideration beyond the principles agreed in the original ethical code of conduct. Winter and Munn-Giddings (2001) propose a number of ethical considerations and these are used here as a framework for discussion of ethical issues that arose during this study.

4.10.1 The value of the project

The use of an action research approach enabled the project to focus on the concerns of those in the practice setting and, as Winter and Munn-Giddings (2001) note, these guiding principles of improving situations and taking responsibility for the well-being of others, distinguish the ethical basis of action research from other forms of inquiry. Winter and Munn-Giddings (2001) suggest asking 'what's in it for me?' to explore the extent to which individual motives might be impacting on the project. I wanted to carry out a study that would be suitable to write up for my PhD, but I held no strong views on the topic area or how the study needed to progress. Because of this flexibility, it is unlikely that my personal motivations played a part in shaping what happened. It was the directorate managers, rather than the IPCCs and their interprofessional colleagues, who initiated the study but, once it was underway, as has been illustrated earlier in the chapter, the action research approach promoted fuller collaboration by all participants in directing the course of the inquiry.

4.10.2 Informed consent

Winter and Munn-Giddings (2001) emphasise the importance of voluntary participation, the right for participants to withdraw from the project at any stage, the provision of written information about the project to potential participants and the seeking of permission prior to tape-recording and before the inclusion of participants' data in any material that is published or circulated to others.

Prior to their involvement in the study, each participant was given written and verbal information about the project and then invited to take part. Given the requirement for flexibility of design in action research it was, however, impossible to state in advance what the project would cover and what data collection this would involve. Although the more formal data collecting opportunities, such as interviews and focus groups, were always preceded by a re-negotiation of involvement, more informal interactions were not. Most day-to-day participation in the study took place on the assumption that people knew from their managers about the project, were willing to take part and would feel able to withdraw if they wished. On reflection, it would have been better to build in a regular review mechanism – perhaps every few months – to remind people of their rights as research subjects and review their wish to be involved.

Another consideration here is the extent to which practitioners, particularly the IPCCs, felt obliged to take part. The IPCCs' managers were involved in initiating the study and this could have meant that IPCCs felt they had no choice but to take part. This potential difficulty was overcome by developing an open relationship with the IPCCs in which they were encouraged to share issues and concerns they had about the study. The consent of the IPCCs was sought each time data collection involving them began. The IPCCs used these mechanisms as and when they needed. For instance, at one point, a number of researchers were involved in collecting data and the IPCCs became concerned at being overwhelmed with researchers. They complained about this and the degree of contact between them and the research team was streamlined to reduce unnecessary contact.

4.10.3 Protection from harm

Winter and Munn-Giddings (2001) indicate that, in spite of the principles of improvement and enhancing well-being that are inherent to action research, some

parts of the process may be quite painful emotionally to those taking part, and that there is a need to plan the project to minimise such pain and to make support available if it is needed. In addition, Winter and Munn-Giddings note the possible dangers to participants' 'reputations' through the project process and report publication (p. 222). A number of measures were taken to promote confidentiality and anonymity and these are outlined above. Meyer (2001b) supports these concerns when she notes that in action research anonymity and confidentiality are not possible to achieve fully.

I worked closely with participants to promote ownership of the findings, sharing them as they emerged and inviting active comment on drafts of written materials. To date, participants have asked that the Trust and directorate be named in written material for external publication, as they are proud of their involvement in the work. The passage of time has also helped this openness, as it could be argued that the issues identified in any report are not necessarily present today.

However, issues related to confidentiality and anonymity did emerge during the action research process. The key issue was that, while it was easier to protect the identity of individual IPCCs, this study exposed some working practices and views on their practice that were difficult for them and sometimes others to appreciate. Aware from the beginning of how uncomfortable such close scrutiny can be, I worked hard to set up a good relationship with the IPCCs that would enable them to let me know if they were unhappy. This included meeting with them regularly, keeping them informed of the progress of the project and sharing findings with them before anyone else saw or heard them.

A threat to job security is an example of how powerful study findings can cause harm to participants. As early data began to emerge, one IPCC (apparently jokily) commented that study findings might indicate that the role of IPCC was not needed. I took this comment seriously and asked their manager to reassure them that this would not happen. Although it was possible to predict from the data that had been gathered that the study would probably not threaten the IPCCs' job security, in retrospect, such a promise should not have been made. In action research, the impact of study findings cannot be predicted, can be out of the control of the action researcher and can be affected by personnel and other changes outside of the study. In this instance, the manager who gave that assurance left the Trust

after a few months because of organisational restructuring, and the IPCCs again became anxious as to the impact of study findings on their job security. Because they had already been given reassurance, I did not immediately perceive the implications the change of manager had and it took an extreme reaction from the IPCCs to the circulation of data about their accountability for me to realise that this anxiety had re-emerged. This highlights the importance of keeping an awareness of how events external to the study may affect what happens within it, and that agreements made with participants may have to be re-visited in the light of such events.

4.10.4 Honesty

Winter and Munn-Giddings (2001) recommend that honesty in explanations to participants, and in reporting and analysing data is absolute. I maintained honesty in my dealings with participants throughout the study and I found open communication to be essential in my relationships with participants. This included honesty in the analysis and reporting of data.

In conclusion, a commitment to ethical practices necessitated a continual review of the impact of the process on participants and a continuing negotiation of the nature of their involvement. The ethical implications of the study were of greatest importance to the IPCCs, around whom data collection was usually focused.

4.11 Chapter summary

This study explores the issues arising from the development of a new role in health care. The study is located in the participatory paradigm that incorporates inquiry that is with, for and by people and that privileges practical knowledge that prompts positive social action. An in-depth relationship between study participants is necessary for such practical knowledge to emerge, and in this paradigm, traditional distinctions between researcher and subjects are blurred. One form of inquiry in the participatory paradigm is action research and a professionalising form of action research has been used in this study.

In an inquiry of this nature, the account that results is dependent on a host of factors, not least the particular features of the study setting, the participants in the inquiry and the values and intentions of the lead investigator. I do not claim that the findings in the following chapters represent 'the' account; they represent one

account only. However, a range of features about this study underline the importance of this account and its relevance to practice in this setting. These features include my in-depth relationship with the study setting and participants, the length of time that the inquiry took place over, and the range of methods used for inquiry and action. It is also possible that the findings have a relevance that extends to policy and practice beyond the study setting, and this is explored further in subsequent chapters.

5   Characteristics: shifting from clerical to professional

This study set out to explore the issues arising from the development of a new flexible role in an acute medical in-patient setting and to seek opportunities to develop practice further. In this chapter, the first objective of the study is addressed, that is to describe the characteristics of the IPCC role. Data sets from the exploration phase of the study are mainly drawn on in this chapter, and these include data from my field notes (total n=110) and from interviews (total n=37), focus groups (total n=16), documentary analysis (n=83), and the patient profile (n=407).

The first section in this chapter looks at the IPCC role set out in the original job description. The second section examines a shift in the IPCC role away from the job description and the third section examines how the content of the role changed to a focus on the discharge planning of complex patients.

Findings in this chapter highlight the shifting nature of the IPCC role. The role was designed with inherent flexibility, so that the IPCCs could do whatever was necessary to move patients through their hospital admission quickly. Over time, this flexibility enabled a shift in the activities of the role to encompass core work previously undertaken by nurses.

5.1   Job description reflects administrative support role

This section explores the characteristics of the IPCC role outlined in the original job description and illustrates that the role was conceived as an administrative support role to the interprofessional team.

From the job description (see Appendix 5, p. 228) it can be seen that the primary aim of the IPCC role was to ensure that in-patient stays are co-ordinated, so that length of stay is dictated solely by clinical need, rather than delayed for organisational reasons.

The clear list of duties set out in the job description include ensuring the accurate recording of information regarding a patient's admission, establishing relationships

with other departments to ensure timely investigations and speedy access to medical notes and X-rays, using information gathered to forewarn of potential discharge problems, collecting and screening social services referrals, and liaising with social workers and community services to facilitate the timely discharge of patients. Interview, focus group and observation data show that many of these administrative duties had remained an important part of IPCC activity over time.

> It is just simple things - like this morning - I went to see a new patient but I didn't know what her previous mobility status was, she is living in a nursing home and we didn't have a phone number for that so one of the care co-ordinators said do you want me to find that out for you, which saves me sitting down trying to get through to directory enquiries to find out a phone number to ring the home. (Physiotherapist, 09119M[20], FG[21])

> [Our IPCC] sort of draws it all together, I mean she's the one you're looking for on the ward round and she says 'oh by the way, do you know that Mrs so-and-so's house blew up three days ago and so you won't be able to discharge her'. (Doctor, 08060J, FG)

> It's administrative support for the consultant's team, lots of running around. It's saved doctors' and nurses' time, test bookings and results, referrals to other consultants or disciplines. It's sorted out lots of admissions stuff, making sure that the details are correct. (Social worker, 02128, Int[22])

> I suppose a part of our role is not to take away duties from the junior doctors but to assist them in as much as to find one tiny, although vital, piece of information. It can take all day to get the right number and the right person to talk to, so that can elevate the doctor and allowing them to get on with patient care and also it would have probably ended up through a nurse to be sat on the phone to do this and, you know, they just haven't go the time to do that sort of thing so that is a function whereby we are helping and intervening there. As I say it can take hours, it can take the whole day to find out. (IPCC, 07128, Int)

> Monday morning: IPCC phones psychiatric unit to check on bed for Mrs B[23] (also other IPCC asked her to check for two other patients). Psychiatric unit will call back (delay because disagreement between care of the elderly and psychiatric unit over where patient should go). IPCC checks computer for Mrs C on infection control ward – still on that ward. Phoned care of the elderly to see if able to take two delayed discharge patients due to go there - not taking any at present. Phoned social worker but not in. Bleeped house officer re Mrs M who was referred to

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[20] Indicates location of data on NUD*IST database. Each set of numbers/letters represents a different interview, focus group, field note, etc. Final letter indicates which focus group (see Appendix 3)
[21] Focus group data
[22] Interview data
[23] Patients' names have been changed

psychogeriatric department at Trust T. House officer returned call and updated IPCC on Trust T progress and delays over weekend (turns out Trust T only reviews cases on Tuesdays). Phoned social worker again about two patients but on other line – message left to call her back. Bleeped bed manager at [Trust's satellite hospital] who returned call about two patients awaiting cardiac catheterisation there – no beds available today. (Field note extract, 21020: 21-38)

This section reflects a role in the job description that is an administrative support role to the interprofessional team. Interview, focus group and observation data show that many of these duties had remained a part of IPCC activity.

5.2   Working beyond job description

Over time, there was a shift from a fully administrative role to one that included aspects of the core work of registered workers. This was indicated by data generated from interview, focus group and observation data. These data demonstrate the IPCC role included significant patient contact, leadership over interprofessional colleagues and independent decision-making. Comparison of data between the original job description and data arising from practice observations and participant accounts (Appendix 6, p. 232) reveals the IPCCs to be working beyond their original job description. An inherent flexibility to the role had enabled this shift to occur.

5.2.1   Flexibility enabled shift

The IPCC job description reflects a clear-cut list of duties. However, practice observations and participant accounts reflect an inherent flexibility to the IPCC role that enabled them to respond to perceived needs as they arose and that, over time, had enabled a role shift to occur. Interview data reflect that the value attributed by managers to the perceived flexibility of the role had given the IPCCs the authority to alter the focus of their work. While each IPCC had developed their own style of work, their overall roles had shifted in the same direction.

> They do work differently [from each other]…I don't think that is wrong, because what I think comes out of it is that they are all effective in the way they work (Manager, 13070, Int)

The key objective of the role was described by managers as doing whatever was necessary to move patients through their inpatient stay as quickly as possible. This

gave the IPCCs the authority to be flexible in what they did and how they achieved this aim:

> At the end of the day my objective is to ensure that there is nobody in this hospital longer than is currently necessary. And, if every week [the IPCCs] can produce a valid reason for why the patients are all here and no reason why they shouldn't be here then they're achieving that objective and that's the core. How they achieve it and whether one [IPCC] might get to it two days quicker than another [IPCC] is too subtle to be bothered with at the moment. (Manager, 11128, Int)

Managers and IPCCs also stated that the role's flexibility meant that IPCCs could respond with whatever activity was required to meet an individual patient's needs. IPCCs and their managers often discussed the role as if its flexibility meant a freedom to do things that would otherwise not be seen as anyone else's responsibility. This type of activity is reflected in the observation data. For example, field notes reflect an instance of an IPCC arranging care for a patient's dog while the patient was admitted to hospital.

> I think we tend to pick things up as the problems arise so you can't really put things down you know items 1, 2, 3, 4, 5 in a job description of what you do because different things arise each day. We might you know say to the doctors we'll sort that out for you. It might be something really simple or something quite complex that need a lot of telephone calls to different places just to try to gather a particular piece of information, so you can't really define a job description in set categories. (IPCC, 15020I, FG)

The flexibility authorised by the IPCCs' managers had thus enabled the role shift to occur.

5.2.2 Key role in decision-making developed

Over time, the IPCCs developed a key role in decision-making about patients, including using information gathered to make independent decisions. This role was not reflected in the original job description.

For instance, the observation data demonstrate that IPCCs identified patients in accident and emergency or on the ward early in admission who were perceived likely to benefit from their input. They selected patients using a combination of pre-determined criteria (for example, patient has had a stroke, patient is over 65) and/or following a request from interprofessional team colleagues. The IPCC would then usually consult the patient's nursing and/or medical documentation, and

may supplement this by questioning the patient and/or their family. These sources were used by the IPCC to gather information on the patient's living situation, clinical problems, investigation needs and any likely discharge delays. These practices, commonly reflected in the observation data, illustrate how IPCCs often selected patients for their input independently from referrals from interprofessional colleagues and decided on the depth and scope of initial assessment they performed.

The observation data reflect that the IPCC would then decide, often independently (but at other times, in consultation with an interprofessional colleague), what (if any) input the patient needed that related to the patient's discharge from the service. If such input was required, the IPCC immediately tried to enable this input at an early stage. This frequent interpretation of the information gathered and independent decision-making are not reflected in the IPCC job description. The following field note extracts give a flavour of the type of information that the IPCCs gathered and how it was then deployed:

> IPCC2 told social worker patient was very short of breath, sisters think he's not coping, lives alone, by the sound of the sisters doesn't do a lot. Patient agreed he may need help with cleaning and that. 'Speak to him and see how you feel'. (Field note extract, 13089:85-94)

> IPCC3 to physiotherapist: He tells me he's coping okay but I'm worried about his falls. Could you have a look at him, see what you think and I'll do an [occupational therapy] referral as well (Field note extract, 19089: 120-129)

> IPCC2 to social worker: She's very sweet. She's all there. She's worried about managing on her own at home with the falls she's been having and the thought of maybe going into a home has been in her mind. She hasn't been eating for a month and maybe, once she's eaten something to get her strength up and maybe she gets better, she could go home with support. But perhaps you could go and have a chat with her (Field note extract, 13089: 3-10)

Study observations also reflect that, once patients have been selected, the IPCC then retained a central role in discharge co-ordination by regularly visiting the wards to liaise with the interprofessional team members involved in that patient's care. Liaison included gathering information, sharing information, discussion and joint decision making. It is clear from interviews and focus groups with the IPCCs' interprofessional colleagues that they viewed the IPCCs as central in knowing and

co-ordinating what was going on for individual patients. This was viewed as a change in practice from using nurses as the source for this sort of information.

> If a social worker is asking what's happening, I can phone [the IPCC] and ask and she can tell me because she knows what's happening to each individual (Doctor, 15020F, FG)

> Although [the IPCCs] have a big caseload, they used to amaze me if I'd ask that someone who'd been in like 6 years ago, they'd know all the out-patients appointment and all this sort of family history and brothers and all the rest of it. And, importantly, very sort of aware of the individual. (Social worker, 15049, Int)

> I have to say that if I wanted to know if someone had been referred to OT, I don't go to the nurse anymore because the nurse often says 'I don't know' or 'I'll go and check in the Kardex[24]' in which case [the IPCC] has probably written in the Kardex anyway'. (Physiotherapist, 15020F, FG)

> For the co-ordination role, the link with the ward, [the IPCC] has her finger on the pulse with regard to the detail of what's going on regarding the patient's treatment, etc. (Social worker, 13128, Int)

Observation data and participant accounts also reflect other aspects of practice and decision-making that were independent of other team members. For example, ward visits by IPCCs were used to check the medical and/or nursing documentation for accounts of patient progress and to talk to patients and/or their family to gather more information or provide information on plans made.

> Wednesday afternoon: Onto admissions ward for IPCC to go through Kardex of all patients to see if any input required. A name came up which IPCC recognised – has had previous involvement but can't recall exactly what. She will check on another new patient who is 75 with unstable angina, lives with her husband, not sure if she has social services or not. Asked ward manager about this patient who said 'she's fine'. IPCC: 'does she need anything? No OT or anything?'. Ward manager: 'no'. Checking ward's book against own patient list to see where patients who were on admissions ward have moved to. Asked ward clerk about a patient and what input he had last time. Ward manager checked that another patient had been referred to IPCCs. IPCC went to see patient but she was asleep so IPCC told staff nurse she wanted to see patient later. (Field note extract, 18089: 270-96)

> If I go to speak to a patient I'll try to tell them exactly what I do, I'm not a social worker but I can help to refer you to one. Little things like often patients come in and they've not collected their benefit or they've not paid their rent and they are really worried that they haven't paid their rent. So rather than get a social worker involved to do anything, we will phone up

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[24] Kardex is a common term used for the nursing documentation

the housing people to tell them that this patient is in and can you make a note of the reason that he hasn't been down to pay his rent, he is really worried about it. (IPCC, 08128, Int)

These findings provide more detail of the IPCC role in actual practice, and illustrate the central role that IPCCs now played in decision-making in the team, and the extent to which they operated and made decisions independently of other team members. This independent level of functioning was not reflected in the original job description.

5.2.3   *Significant patient contact developed*

It is clear from the observations and IPCC accounts that they developed significant relationships with some patients, often acting as the key point of contact for the patient and family as to the patient's social situation and discharge arrangements.

> Wednesday morning: IPCC called [out-of-borough] social worker to tell her about a patient (who was blind) and that she couldn't go home today. 'What she's worried about is curtains at the window because of getting dressed…she's got a daughter but she's only 15…she's worried about her curtains, bedding, and the fact that BT[25] are coming tomorrow to do her telephone. I can't put her on a train because she doesn't know where the flat is and her poor sight…has she got any bedding, do you know?…Oh good, so curtains she's got to worry about when she goes home…so will you let me know when you're going to meet her again with the care manager…and I'll try and sort out about the BT thing…she needs someone to get basic shopping when she goes home, so if she has a [hypoglycaemic episode] or anything, she's got something in…depends when she leaves. If it's an afternoon, that's better, because she can have a cooked meal before she goes…she'll just have to get undressed in the bathroom until her curtains are sorted out'. (Field note extract, 18089: 193-206)

> The patients that are perhaps waiting for nursing homes or residential homes, we get involved with their relatives as well because they are here for a long time while they are waiting for things to be decided and we tend to liaise with the social worker, ourselves, the relatives and funding panel and the home that is eventually found for the particular patient. So that type of thing we do get involved in and that's rewarding when someone goes to a home that the relatives are really, really pleased with. (IPCC, 08128, Int)

While the IPCC job description mentions a job purpose of 'acting as the patient's advocate [in facilitating appropriate and timely discharge]', the duties listed in the remainder of the job description do not indicate patient contact of any kind

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[25] British Telecom, a 'phone company

(although liaison with families is listed as a task). As shown here, observation data and IPCC accounts indicate that patient contact is in fact an important part of IPCC working.

5.2.4 *Leadership over interprofessional colleagues developed*
A further area in which IPCCs were practising beyond their original job description was in taking a leadership role in some aspects of interprofessional working. Interview and observation data reflect that this included prompting, chasing up, instructing and overseeing the speed and efficiency of parts of the work of interprofessional colleagues. The authority for this aspect of working appeared to come from the operations managers and doctors pushing for acute efficiency.

> [The IPCCs'] focus seems to be in making sure we're doing our job. That's certainly how I felt, that they're there to make sure I'm doing my job. (Social worker, 09039, Int)

> The [IPCC] helps prompt earlier thought on whether or not an OT referral is needed. (Occupational therapist, 19019, Int)

> One of the [non-English speaking] ladies that I had, she was waiting for a special chair to go home and the OTs told us it was going to take four weeks. After four weeks, we 'phoned the OTs and they said they had the chair but now they needed to wait for a special head-rest and that would take another six weeks. I told the doctors this and they said if it's an outside company supplying the chair, be a bit stroppy and say we'll take our business somewhere else. So I phoned the OTs and they said it was an outside company. So I said 'well, they're not happy at all for this lady to wait another six weeks, the family are not happy because we have already given them a date, and they have been training to transfer her and do her gastrostomy feed, the lady is getting more agitated because she can't make herself understood without a family member, she really wants to go home, she's getting depressed, is there not some way we could push it quicker?' So she said 'well I don't think so'. And I said ' well would you mind trying?'. Anyway she came back in about an hour and said that there was a chair they could loan us until hers was made. They would bring it on Monday, this was Friday. (IPCC, 11059, Int)

> Manager: The tension for us as a Trust is that we have 30 people every day coming in the front door and we have to find a bed for those people. We have 40 less beds for general medicine than we had a year ago and probably a 10% increase in admissions. We have no nurses half the time and a population that's coming in that's sicker. If you could come up with a way of us dealing with it which means that people will probably get the standard of care that they need, I'd be grateful, but unfortunately it's a treadmill – we have to churn patients in one end and churn them out the other and that's what we have to do.

Social worker: And the [IPCC's role] is really to facilitate that churning out the other end.

Manager: Exactly right, and that's why it's very difficult. The point that somebody made is that they're the ones delivering the message when it's not actually their message. (Focus group extract, 05039A)

As the above examples illustrate, elements in the IPCC role of leadership over interprofessional colleagues are reflected in IPCC practice and interviewees' accounts of practice, but not in the job description.

5.2.5 *Some activities dropped*

Along with taking on new responsibilities, the IPCCs had also stopped doing certain activities that were originally conceived of as part of their role.

I think at the beginning because we weren't sure of the role we did a lot of fetching and carrying for house officers, you know running [echocardiogram] forms down and things like that, which unless I am going that way now, I wouldn't say 'well give me the forms, I'll do that for you'. But I think that was just a way of getting our foot in the door and finding out where different departments were. (IPCC, 11059, Int)

At a meeting with some managers from another Trust (who were visiting to find out how the directorate managed their acute admission processes) one of the IPCCs said 'we used to do a bit of bed managing but that was distracting from the real work of the role'. (Field note extract, 26039: 22-24)

[The IPCCs have] made decisions about things that they say are a waste of time and we accept that and I'm sure that's true, but things like, you know, they used to always go on the post-take ward round and now they never do because they say it's a complete waste of time actually - standing talking to the doctor pretending it's useful. (Manager, 11128, Int)

This 'dropping' of certain activities that were no longer seen as key to the role is interesting because it represents a loss of flexibility over time. Originally conceived to take on work that would save the time of interprofessional colleagues or because no one else would see that work as their job, over time, the IPCCs had also developed their own criteria for what was and was not part of their role. This suggests a desire for role clarity rather than flexibility.

5.3 A shift to discharge planning

This section looks at the content of the work taken on by the IPCCs and argues that the work had shifted to discharge planning rather than a focus on the entire inpatient stay. The discharge planning role was a lead one that substituted for

nurses' responsibilities in this area. The section will examine how this role shift occurred and the value nurses and IPCCs placed on work in this field.

Participant accounts reflect that the content of IPCC work had shifted away from a general focus on inpatient processes to a specific concentration on discharge planning.

> What has ended up happening is that [the IPCCs] do devote quite a lot of time to discharge. I'm not sure how much time they are able to spend on the front end of the patient's stay. (Manager, 11128, Int)

> This is I think to do with a shift of emphasis from covering the whole patient stay over to discharge, partly 'cos discharge is so important and partly 'cos they're so good at it. I think they could possibly do more around the in-patients' stay. Picking up referrals, whether people come and see patients, getting information from other places from GPs and other hospitals. (Doctor, 06060, Int)

> We are aiming towards discharge all the time. I think from the moment patients come in we are trying to plan their discharge as smoothly as possible. A couple of years back, we used to find that the people were ready for discharge and then suddenly they can't go because they need things sorted out and so therefore that was like another two or three days that they were taken out of bed and waiting for services to be set up when they really needn't have been there. I think that's a big part of where this job has taken off in stopping that, but we still get hiccups, but I think a lot of it has stopped because we are trying to plan it. (IPCC, 08128, Int)

> The [IPCCs] are particularly involved in arranging a discharge or additional information that is relevant when a patient just comes in – information you need to know that will relate to discharge. (Doctor, 15049, Int)

This shift to discharge planning continued throughout the course of the action research study, as noted by the IPCCs during their final focus group in the study:

> Researcher: Are you doing anything different now that you were doing in 1998?

> IPCC: Yeah, more work! *(laughs)* I think we're more focused on discharge planning than anything else. I mean, I suppose we'll always be called care co-ordinators, but to be quite honest with you, I think we should be called discharge co-ordinators, because a lot of the other jobs go out of the window if you haven't got enough time. (Focus group extract, 23060P, FG)

By the close of the study, the weekly delayed discharge meetings were now held on a daily basis. These meetings were now not just for directorate patients, but for

patients across the Trust. These new arrangements had intensified the IPCCs' focus on discharge planning.

> I met with the senior nurse today. Over the winter, the delayed discharge meetings have been held daily and have gone Trust-wide. This is to enable the Trust to keep on top of emergency admissions. The senior nurse told me that [the person running the meetings] has been really impressed with the IPCCs and how on top of delayed discharges they are. The meetings have been so helpful, they will continue daily indefinitely, even though winter is now over. (Field note extract, 14040: 1-8)

This provides strong evidence that the IPCC role had continued to shift over 3½ years after its introduction.

Observation data reflect that the discharge planning work the IPCCs took on represented a leadership role in discharge planning, a role previously held by registered nurses in the Trust. Field notes reflect numerous examples of IPCCs initiating referrals to social work or occupational therapy (or screening and if necessary changing or removing referrals by nursing), acting as the source of information on community services and for what was going on with a particular patient, attending the weekly interprofessional meetings (which nurses often missed) and coordinating the input of different interprofessional team members.

5.3.1 Substituting for nurses

Nurses are named in the Trust discharge policy as the lead profession in discharge planning. The policy states 'each discharge should be organised and coordinated by a named member of staff (i.e. the Named Nurse) who should be responsible for ensuring plans are effectively completed and communicated to all concerned' (p.4). However, findings show that it was mostly the IPCCs undertaking the lead discharge planning role on the general medical wards, particularly for patients with more complex discharge needs. While nurses continued to have a degree of involvement in discharge planning, it appears from the observation data and participant accounts that the IPCCs had the primary responsibility for getting the work done in practice.

> At least there is someone [i.e. the IPCCs] tracking that patient through the patient's stay and you can quickly assess their home situation, what their home needs are from that one person and drawing on work that has been done before, rather than a nurse starting from a blank sheet of paper and planning their discharge. (Nurse: 13049C, FG)

> We often get a [social work referral form from nursing staff] with no information at all, like 'lives in a flat', so rather than wasting the social worker's time, we will come over to the ward, find out all the information about the patient, we actually find out as much information as we can on why that person needs a social work referral. Some of the time it's not even a social worker that's needed. (IPCC, 15020F, FG)

> IPCC rang [admissions ward] to see if MF[26] is going home today. He has X-ray at 2.15 p.m. Then rang placements officer about MA's hostel but she wasn't around. Asked for social worker and asked her about finding hostel at address patient had said. Discussed FK – social worker is collecting in reports for panel on Thursday - still awaiting reports from FK's residential home and [elderly mentally ill] day care centre. [Another IPCC] offered to call day centre. Bleeped doctors to remind them about [weekly interprofessional meeting]. Rang day centre and left message for woman responsible for writing reports. (Field note extract, 10089:189-99)

Nurses consistently cited a lack of their time as the reason why IPCC input was helpful.

> The [IPCC] is someone who can spend more time with a patient investigating social issues, some of which are quite complex and this doesn't get in the way of other clinical priorities interfering with that role. (Nurse, 13049C, FG)

> I think patients get a better deal with [an IPCC] in place. I try to imagine our ward life without that input and it is quite difficult. [Patients] want to have time to talk over things - otherwise on other wards I have found myself doing a social assessment and it being a checklist really, just because you're so pressed for time and that's not the way to approach it. I think with that role of the [IPCC] they can sit down with the patient, the patient will talk about why the sister-in-law doesn't help with the shopping and the family row they had that preceded that problem – it's very sad that nurses don't have that time because that's something we've lost really on a realistic basis on the wards, but I think patients need to talk about that and need to talk about their social situations and that gives them that time, often to do that. (Nurse, 28049, Int)

The lack of time cited by nurses could be accounted for through nursing staff shortages. At the time of the study, the Trust was in the grip of a severe nursing recruitment and retention crisis. In 1999, the Trust's vacancy rate for nursing and midwifery was 21%, its turnover rate 29% and its retention rate 76% (The Royal Hospitals NHS Trust 1999). These shortages were reflected nationally, the most acute shortages being in inner London (Buchan, Finlayson, & Gough 2003; Cameron & Masterson 2004). This, along with continuing efforts by managers to

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[26] Patients' names have been changed.

reduce the hours worked by junior doctors (and therefore the substitution of parts of their work by nursing personnel) had meant that nursing staff were limited in the comprehensiveness of care they could provide. Often, the nurses providing care were bank or agency staff that were not part of the ward's permanent nursing team.

> It may be at the beginning of the week all runs smoothly, and there's a named nurse there who makes sure it's all done, but towards the end of the week when they're not on anymore and you've got [an agency nurse] there who doesn't know the patient you just get 'I don't know', and a lot of the comments probably when nurses have said to patients, 'I don't know' is from somebody who doesn't know, doesn't care, they're not gonna be there tomorrow, and unfortunately we can't resolve that because there is a national [recruitment] crisis which is why it's fantastic we have people like the care co-ordinators that seem to fill that gap, that they are the fountain of knowledge, they've got their finger on the pulse. (Nurse, 08060K, FG)

> I'm becoming more worried about de-skilling nurses than I think I was previously. But because we haven't got enough trained nurses, we can't get enough trained nurses, we have to say "What is it that they should be doing, and what is it that other people should be doing?" and maybe we have to accept that. But I think we should be up front in saying, and that means the nurses of the future will have a big knowledge gap, or this big experience gap. (Manager, 27049, Int)

The flexibility of the IPCCs also enabled them to be in a better position than nurses to carry out the bulk of discharge planning work for some patients. The IPCCs could provide the continuity that nurses could not, because they could follow patients as they were transferred from ward to ward, and also were unaffected by the mismatch between medical teams and the ward bases (see p. 10). This was in contrast to nursing staff who were 'ward-bound' and therefore dealt with multiple teams of interprofessional colleagues who cared for patients on their ward. So the flexibility (and inherent mobility) in the IPCC role meant that patient-centred care in the face of the current organisational arrangements was easier for them than for nurses.

This aside, the lack of time cited by nurses necessitated decisions about the best use of nursing time. The following two sections examine the decisions that were made about what nurses retained and what IPCCs took on from nurses.

5.3.2 *Discharge planning valued less than technical medical care*

The accounts of nurses and managers reflect a value attributed to IPCC work because it enabled nurses to concentrate on physical care, particularly the performance of technical medical work.

> The dependency of the patient is so much greater and therefore [the nurses'] focus of energy is actually to make sure that Joe Bloggs stays alive, giving somebody else to concentrate on actually how do we get Frank Smith home, because we've kept him alive, and it's that balance, isn't it, and I think it's a dilemma (Manager, 27049, Int)

> Nurse: The [IPCC] can have a 15 minute chat with a patient about all issues which realistically with quite dependent patients I unfortunately can never give - and that's the bottom line.
>
> Researcher: Now in your role do you think you are perhaps concentrating on the physical side of that patient's care, the actual maintaining their physical function, and so you stay further and further away from the social side of it.
>
> Nurse: I think in practice, if you were to observe my daily life on the wards, I think that is the conclusion you would unfortunately reach, really.
>
> Researcher: If I observed that, would it be realistic, or do you still feel you ....
>
> Nurse: I think we have a feeling we still see the patient holistically and we approach the patient holistically, but in terms of the number of tasks you're taking on with that patient, obviously you still help them with their washing etc., sitting up in bed, making them comfortable, check their pressure areas, and all those things that give you time to spend with and talk to the patient, but when you've got 6 people on [intravenous infusions], antibiotics, getting ready to go for lung function tests, having epileptic fits etc., realistically I don't have time to sit down for 10 minutes to talk unless I happen to be [administering an intravenous drug] or I can combine it with another interaction which is not the way it should be (28049, Int)

Nurses' comments implied that the nursing role 'should' include aspects of discharge planning but that, given the reality that the work available outstripped the capacity of nursing staff alone, a priority had to be given to physical care, particularly technical medical tasks.

> The less I can do regarding someone's discharge the better…because of clinical priorities and clinical demand. (Nurse, 13049C, FG)

So the nurses valued technical medical work more highly than discharge planning work. Their priority was to make sure the physical care needs of patients were met

and, because of nursing shortages, this meant that discharge planning, a lower priority, had to be handed over to others. One ward manager also cited the need for acute efficiency in redefining who does what:

> [The IPCCs] do not stray inappropriately into nursing or social work roles. Whatever gets patients through the system is the right thing. (Ward manager, 09118, Int)

These findings raise the question of why discharge planning and not other aspects of nursing work was seen as being suitable to be handed over to another group. The passing on of discharge planning suggests a priority order to aspects of nursing work, in which nurses see the work of discharge planning as routine enough to be managed by a group without qualifications.

5.3.3 *Taking on the most complex patients*

Although, as illustrated in the previous section, discharge planning may have been seen as routine enough to be managed by a group without qualifications, IPCCs actually took on the discharge planning work of the most complex patients. Nurses acknowledged that the IPCCs were more likely to become involved with patients with more complex needs while they (nurses) retained the responsibility for arranging the discharge of more straightforward patients.

> You would only get [the IPCCs] to come in if you didn't have the time or you didn't feel that you would be able to manage it properly, bearing in mind your workload. So you know, if there was a lot of input needed to be made with lots of different people then that's when I would [get the IPCC involved]. You know, I wouldn't call them in for every discharge I did (Nurse, 11059, Int)

> If I can see discharge is going to be difficult, I don't want to spend hours on the 'phone so I contact the care co-ordinators. (Nurse, 11118, Int)

These claims by nurses that IPCCs took on the work of patients with more complex discharge needs are supported by findings from the patient profile that illustrate that, relative to directorate patients as a whole, the IPCCs worked with patients who tended to be older, sicker and have a longer length of stay. These findings are displayed in Tables 5.1 to 5.3.

Table 5.1 illustrates that the mean and median age of IPCC patients were greater than for directorate patients as a whole. Older patients have been identified as being at greater risk of a delayed discharge than younger patients (Department of

Health 2001b; National Audit Office 2003) and, as illustrated earlier, old age was one of the criteria that prompted the IPCCs' selection of patients.

Table 5.1: Age of IPCC patients and general medical patients (April-August 1999)

Age (years)	IPCC patients	All general medical patients
Mean	68	57
Median	72	60
Range	17-96	Not available
Standard deviation	16.1	Not available
Number	394	2296
N missing	13	0

Table 5.2 illustrates that the mean and median length of stay for IPCC patients were greater than for directorate patients as a whole. This suggests that IPCCs were successful in their selection of patients with more complex needs.

Table 5.2: Length of stay of IPCC patients and general medical patients (April-August 1999)

Length of stay (days)	IPCC patients	All general medical patients
Mean	17.1	8.8
Median	11.0	5.0
Range	1-110	Not available
Standard deviation	16.1	13.1
Number	407	2296
N missing	0	0

Table 5.3 illustrates that the in-hospital mortality rate for IPCC patients was greater than for directorate patients as a whole. Mortality rates can be used as an indicator of sickness levels (morbidity) in a population and the findings in these tables

suggest that IPCCs were successful in identifying and working with the most
vulnerable patients, leaving more routine work to nursing staff.

**Table 5.3 In-hospital mortality rates of IPCC patients
and general medical patients (April-August 1999)**

IPCC patients	All general medical patients
10.7%	4.4%
26 out of 242	102 out of 2296
N missing = 165	N missing = 0

This tendency for the IPCCs to focus on and work directly with the most
vulnerable patients reflects a role that is not a routine, administrative role and
suggests that IPCCs had taken on the discharge work for the most complex
patients. The need to save nursing time had prompted the substitution outlined
above, but it was the most complex patients that the IPCCs, an unqualified group,
had taken on.

5.3.4   *Only took on core work of nurses, not other groups*

While the IPCCs provided administrative support to all core members of the
interprofessional team (that is, doctors, nurses, social workers, physiotherapists and
occupational therapists), their role shift towards discharge planning represented a
role shift towards the core work of nursing, more so than that of the other staff
groups.   The concentration on discharge planning was also seen by some social
workers in interviews early in the study as an inappropriate overlap of the IPCCs
into core social work. IPCC activities identified by social workers as problematic
included assessing patients prior to their social work assessment to determine what
level of post-discharge support may be required, promising services like housework
to patients, and keeping up patient and family contact once a social worker had
taken on the case.

> There are disadvantages in the way work has been performed by certain
> individuals. They have overstepped the mark. They approach patients as
> potential social work referrals and patients get the impression that the
> [IPCC] is a social worker. There are occasions when the [IPCC] promises
> services. This causes problems when the social worker goes to do an

assessment. The social worker does an assessment of patient needs then has to prioritise. It's not the [IPCC's] role to go up to someone and say we'll sort out someone to do your housework. (Social worker, 02128, Int)

Observation data indicate that some of these practices identified by social workers were a part of IPCC practice. The field notes reflect that IPCCs raised the prospect of placement with patients during their initial assessment and kept patient involvement going after a social worker became involved with that patient. As with the work the IPCCs carried out that was previously nursing work, these activities are not reflected in the IPCC job description or in the Trust discharge planning policy.

However, the findings reflect key differences between the IPCCs undertaking nursing work and social work. Staffing shortages were a feature in both staff groups, although in nursing they were more consistently present. While some IPCC work may have pre-empted social work input, it did not alter the work the social workers then carried out in terms of patient assessment and input. This was clear from the way social workers described their work in relation to IPCC work. The first quote below reflects how IPCCs were able to improve the quality of referrals to social work, but implies that social workers continue to assess patients for themselves once the referral has been received. The second quote (by a different social worker) questions what the IPCCs have to offer that is different from the contributions of the team members already attending case conferences for individual patients. This implies that the social workers do not view the IPCCs as substituting for them.

> I had a session with [two of the IPCCs] and we looked at what would be appropriate referrals to social work in the light of our eligibility criteria within the borough. So the [IPCCs] got an idea of what our limitations were and gave it a bit of a framework, and I think that really did improve the referrals that we assess. (Social worker, 05039A, FG)

> This is a bit specific, but are they actually meant to come to the case conferences? Because that's quite a big dilemma for me, because [another social worker] and I had a husband and wife who we were working with, so there was a husband and wife, there were two house officers, there was only one OT and one physiotherapist and then the two [IPCCs] wanted to come as well. The husband and wife were quite elderly and quite sick, and it was a bit of a difficult situation, I weren't sure of the reasons for the [IPCCs] being there, necessarily. The husband came in and sort of made reference to "oh, is it us against you lot?", and it really felt like that, because there was like, the [IPCCs] decided to step out, which I thought

was really good - that they had that insight to see that. But I've been told by the [IPCCs] that I need to invite them to case conferences. (Social worker, 05039A, FG)

The 'social work' the IPCCs carried out could therefore be seen as supplementary to regular social work input. In contrast, the 'nursing' work the IPCCs carried out was, as reflected above, to compensate for staffing shortages and was therefore carried out instead of what nurses would have done in terms of assessment and input.

5.4   Chapter summary

This chapter has addressed the first objective of this study and has described the characteristics of the IPCC role. Findings show how the role has shifted from its original job description from a purely administrative role to one that includes significant patient contact, leadership over interprofessional colleagues and independent decision-making. This shift was enabled by the role's key characteristic of flexibility, a characteristic encouraged by managers.

Nursing shortages meant that IPCCs had taken on the lead in discharge planning from nurses, although this was not reflected in Trust policy. Nurses gave a higher priority to technical medical care than to discharge planning, although they retained more routine discharges while handing over the complex cases for IPCCs to handle. Neither Trust discharge policy nor the IPCC job description reflect these important shifts in practice.

The next chapter explores the impact of the IPCC role and the issues that have arisen.

6 Impact and issues: positive contribution but lack of managerial systems

This chapter addresses the second and third research objectives and explores the impact of the IPCC role on patient care and interprofessional working, and the issues arising from the role. Data sets from the exploration and action phases of the study are mainly drawn on in this chapter, and these include data from my field notes (total n=110), interviews (total n=37), focus groups (total n=16), and the documentary analysis (n=83).

The first section in the chapter looks at the impact of the IPCC role on interprofessional practice. The second section examines the impact on patient care, focusing particularly on the issues that have arisen about IPCC competency and accountability. The third section uses my perspectives on the observation data to re-examine manager and practitioner accounts of competency and accountability to reach an overall conclusion on the impact of the IPCC role.

The findings in this chapter illustrate that while the actual contribution that IPCCs make to patient care is generally very positive, a lack of attention to the requirements of the role for competency, regulation and supervision could have negative consequences for patient care.

6.1 Impact on interprofessional practice

The findings below explore the impact that the IPCC role had on interprofessional practice in the directorate and the issues arising from this impact. The impact of the role on interprofessional working can be described in three main ways: a contribution to team working that is valued by team members in spite of some continuing uncertainties about the role, an alteration in communication patterns between team members, and a reduction in nursing input to some interprofessional activities.

6.1.1 *Contribution valued in spite of uncertainties*

It is clear from much of the interview, focus group and observation data that the IPCC role was highly valued by the IPCCs' interprofessional colleagues. This was in spite of an initial uncertainty by staff who were encountering the role for the first time and a confusion about who makes what contribution to team care. Because the role was new and because of its inherent flexibility, uncertainty about the role tended to be high for new staff in the directorate. All new doctors received a verbal and written introduction to the IPCC role on induction, and some nursing ward managers ensured that new nurses spend time with the IPCCs as part of their induction.

> I attended the induction for new house officers today. The session was led by the clinical director and one of the operations managers. House officers were handed Standards for Medical Staff (dated May 1999). This includes a section on the IPCC role. The clinical director described IPCCs as an innovative group of staff with administrative background, job purpose to make sure stay is no longer than clinically necessary, anything relevant to doing that is relevant to them. They cross boundaries, communication, liaison, huge resource to you. If you think they can do it, they probably can, however unusual. I spoke to clinical director and operations manager after. They said that during induction sessions, house officers are generally 'itching to get on the wards' and are most interested in learning about the rota. This session was the first one that the directorate had handed out written information about the IPCCs. The clinical director agreed there was a lot to take in. (Field note extract, 04059: 2-20)

> In most wards when a new nurse starts she will contact us as part of their orientation and we will spend half an hour with them just explaining roughly what we do, well you know our role as such. But not all wards do that, do they. Some do, some don't. Therefore some nurses are coming in and they don't know us at all. (IPCC, 15020F, FG)

The IPCCs' managers and colleagues reflected in their interview accounts that, over time, an understanding of the role grew but even when team colleagues became familiar with the role, there remained a sense that IPCCs did more than their colleagues knew about.

> I'm never really sure of their exact role. It would have helped to have been told when I started working here. They are good at putting in referrals, chasing up loose ends. They probably do a lot of work we're not aware of. (Doctor, 12118, Int)

> Well we had that time [with the IPCCs] at our orientation which I must say when I left, although it wasn't anything to do with what they were telling us, I still felt a little bit confused because it was a new role to me and so I

kind of felt well I will learn by seeing which I have, and since then my attitude in my head is clear on what they do but obviously it is not the whole picture. (Nurse, 13049C, FG)

The doctor quoted above had clearly not benefited from the inductions for medical staff evident in the observations. Some interviewees reported a confusion about who did what in discharge planning, and this is reinforced by study observations that highlight differences in practice between the IPCCs. The role's flexibility and mismatch between written Trust discharge policy and actual practice (see previous chapter) can only have exacerbated this confusion.

The [IPCC] has taken on some of the role that other people like nurses do and what happens is sometimes none of us are sure who's going to actually do the discharge. (Social worker, 05050, Int)

I have a concern about who should do what. It varies between patients as to what the nurse does and what the [IPCC] does. This is probably where any confusion comes from. (Ward manager, 11019, Int)

I sometimes think from a nursing point of view, it must be very, very confusing to know who's doing what, and I sometimes think "Do you not know what's going on?" – [nurses] seem to not know, not be able to answer your question, and when I sit down and think about it, I wonder is that because they're so goddamn confused because there's so many people involved. You know, who is doing what? (Social worker, 09039, Int)

It's kind of like who's the key now? Is it the [IPCC] or do you speak to the nurses or do you speak to the social workers. There's a bit of a struggle at the moment. And I don't know whether the nurses would see themselves as losing their remit. 'Cos I think, well, who do I talk to about what and I feel quite confused and I end up thinking...it's not that I get many cases but it's kind of like you tend to lose your focus if you have to worry about 'who am I talking to, what am I doing?' (Social worker, 05050, Int)

The IPCCs have each developed their own systems of working which work for them - selecting patients, documentation. (Field note extract, 08119: 9-11)

Once they learned about the role, most interprofessional colleagues valued the IPCCs' contribution. The IPCCs' role as a source of information for the team, and the timesaving administrative work that IPCCs did on behalf of their colleagues was seen as invaluable.

I think there are quite a lot of advantages [to the IPCC role]. Just because they're somebody who is sort of slightly outside, in that they're not involved in the medical side, they're not providing a therapy input and they are overseeing the whole lot which I think that's a big huge advantage…I think they have a big role in discharge planning, whereas the rest of us all

seem to work on one little area they're looking at the whole package really…I think it makes a lot of our lives very much easier". (Physiotherapist, 15128, Int)

The [IPCCs] are a useful resource for the doctors. They know their way through care of the elderly, community services. (Doctor, 23029, Int)

They act as one person who knows what is going on in every aspect of a patient's admission. This does work in practice. They also [re-start pre-admission home community care]. This takes the pressure off us and means there are less delays. It frees us up to concentrate on other things. (Social worker, 02128, Int)

In summary, understanding of the IPCC role was characterised by some uncertainty, particularly in staff who had not encountered the role before. This uncertainty led to some confusion about who did what, in discharge planning in particular. As practitioners learned about the role, they came to value its contribution, particularly because it saved their time and because the IPCCs were a valuable source of information on individual patients.

6.1.2 *Altered communication patterns between team members*

Also noted by interviewees was the role that the IPCC played in communication between members of the team. This was also observed in practice although not covered in the IPCC job description. One view held by some interprofessional colleagues was that the IPCC role brought the interprofessional team together because of this liaison role between the different team members.

It is just a huge communication point because [the IPCCs] bring the whole team together, so they will often feed things back into the medical team or whatever or liaise between social work and OT. (Physiotherapist, 09119M, FG)

The IPCCs saw their role in this regard as an advantage.

Although they're not actually talking to each other it's positive in that because we are based here all year round we know who to contact, we know numbers; whereas if you are getting new people coming in it can be a process to find out who you need to talk to, what the numbers are. So it is negative in as much as those two people perhaps never talk to each other or even meet but it's positive because the information needed can be supplied a lot quicker. (IPCC, 07128, Int)

In contrast, some team members felt that the liaison role of the IPCC between the team members increased the chance of miscommunication.

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The [IPCC] role sets up another line of communication that gets distorted. I would prefer to talk to, for example, the registrar directly. Things change so quickly. The [IPCC] sets up another bureaucratic process… Our [IPCC] went off sick for about 6 weeks. I thought things worked better because communication was more direct.   (Social worker, 12118, Int)

Perhaps the only thing to say [in identifying disadvantages to the IPCC role] is they are an extension to the team and if you have too many people on a team the chance for the information to get lost is greater. (Doctor, 15049, Int)

In summary, the IPCC role has altered communication patterns between interprofessional team members, by acting as a liaison point. Both advantages and disadvantages were identified from this change.

6.1.3   *Reduced nursing input into interprofessional activities*

The IPCC role also affected interprofessional working by reducing opportunities for nurses to be involved in interprofessional team activities. We saw in the previous chapter how IPCCs rather than nurses were approached by team members for information about what was happening for individual patients.

For me it's a luxury to have the [IPCCs] for I go to them to check everything is sorted rather than the nursing staff. (Occupational therapist, 15020F, FG)

A comment by a ward manager suggested that this was also happening between nurses:

It's simply because [the IPCCs] have all the information. I would pick up the phone and ask [the IPCCs] quicker than I'd ask one of my own nurses. (Ward manager, 15020F, FG)

In addition, the attendance of IPCCs at the weekly interprofessional meetings masked the absence of nurses (who found it difficult to attend meetings because of the mismatch between medical teams and ward bases – see introduction chapter, page 10). This is evident through observation and interview data. The field notes reflect that, while some nurses attended the weekly interprofessional meetings, the meetings continued in their absence, with no regular contingency being made for other team members being informed of the nursing view on individual patients or for informing nurses of decisions that were made in the meeting.

Consultant couldn't attend (usually does). Present: 5 doctors, student social worker, OT, IPCC, physiotherapist arrived later. Meeting ready to go, then IPCC went off to get nurse off ward. Doctor to nurse: Do you

know all the patients? Nurse: some. Discussion of patients. Patient 1. Known to the team. Social worker updated that they were looking for residential home. Doctor: patient seems depressed. Might start him on anti-depressants. Patient 2. Doctor: getting better from pneumonia. Probably needs another week of treatment. Daughter has been to see me about social situation. IPCC: not aware of this. Had agreed with patient/family that no services were needed. Doctor asks nurse: what do you think? Nurse responded with how patient felt about his medical condition. Doctor prompted IPCC to investigate some more. Nurse leaves meeting. Other patients then discussed. (Field note extract, 03128: 2-24)

In the above extract from the field notes (typical of many taken of the weekly interprofessional meetings), the nurse appeared to be playing a passive role, contributing only when asked questions. The only contribution made by the nurse was in sharing how the patient felt about his medical condition. This information was apparently irrelevant in the light of the discussions being held and the nurse failed to convey the relevance of her contribution. It may be that the nurse played a more active role in decision-making about this and other patients outside of this meeting. However, the unclear sole contribution she did make to discussions and the fact that the meeting was able to continue in the absence of nurses after she had left suggested that the meetings were able to function without nursing input. Some nurses suggested that they relied on IPCCs being at those meetings in their place and on the systems set up to ensure that IPCCs communicated with them before and after the meetings.

> All the ward managers agreed that it was hard to take nurses off the ward to go to the meetings, and impossible if the meetings were held off the ward. Some ward managers saw it as a higher priority than others. One ward manager felt that she had suitable systems in place for liaising with the IPCCs before and after the meetings, for working with interprofessional team outside of the meetings, and for popping in to the meetings if there was something to raise about a particular patient - because this worked well, and there was no evidence that patient outcomes were suffering (e.g. failed discharges), she questioned whether it was important that nurses were always at the meetings. (Field note extract from meeting with ward managers, 06060: 37-47)

> Providing you're putting the right things in order to enable other people to make the appropriate decisions and they are linking in and getting back, I think it's okay. (Nurse, 11128, Int)

However, there are no observation data to support these claims by nurses. At no point in the field notes do the IPCCs appear to be preparing with nurses for the interprofessional meetings or briefing nurses about what they had missed. Some

interviewees also noted that there was a lack of suitable systems in place to ensure systematic communication between nurses and IPCCs:

> Ward manager 1: I think there are some [IPCC] personalities we have that are very, very good and they regularly come to the ward and go through the files and pick people up and ask the nurses who are there at that time, what they think should be done and all the rest of it. But with the multidisciplinary meetings it tends to be sort of us grabbing them on the way out or I think quite commonly with us is the ward physiotherapist who lets us know what is going on.

> Ward manager 2: It is not consistent, there is no clear cut approach like 'we go to the ward meeting and this is how we communicate it back effectively'. There is no real clear cut way of ensuring that takes place apart from [the IPCCs] will document in the notes about it, but as I say its not verbalised and it doesn't always get verbalised to anyone, and they might not necessarily tell you all the pieces…if you have got to do something, then they will come and tell you but I don't think it's consistent enough. That is the trouble, it is not consistent enough that you can rely on it. (Focus group extract, 13049C)

What is also of importance here is the level of acceptance of this way of working by the vast majority of interprofessional team members. Nurses clearly saw the attendance of IPCCs at meetings in their place as an advantage given the demands of their other nursing responsibilities, although one ward manager felt that there should be consistency in whether or not nurses were attending:

> One ward manager said, because there was clearly variability at the moment as to whether or not nurses were at the meetings, we should make a decision once and for all whether or not nurses should be at the meetings - there was no sense in the current situation, either you need a nurse there or you don't. (Field note extract from meeting with ward managers, 06060: 37-47)

No other team members raised concerns, with the exception of one registrar interviewed.

> [The IPCCs] take over the nurse's role for the other wards at the multidisciplinary team meetings. It's always a junior doctor who leads the multidisciplinary team meetings[27] and the absence of nursing means that it is too easy for the doctors. Nurses are not really involved in the social side of things which is a shame - I would like nurses to contribute more to the team meetings, so if they have got something important to say, they have an opportunity to say it. I have worked somewhere else where the multidisciplinary team meetings were nurse-led and that worked well. (Doctor, 23029, Int)

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[27] This was not the case across all the medical firms. Each meeting varied in who chaired it.

This general lack of concern either signals an acceptance of the difficulties nurses had in attending these meetings and/or a view that IPCCs were performing effectively in their substitution for nurses. What is clear is that, however unsystematic communication systems may have been between nurses and IPCCs, the IPCC role masked the absence of nurses at the meetings, at least to some degree. Given the reliance nurses had on IPCCs, it would also appear that they had reduced the impetus for the nurses or any other team members to think about what changes could be made to improve nursing input to the meetings.

> I didn't realise this was such an issue about the nurse representation at these meetings because I must admit I very rarely go to them, but that's because I feel very confident in that if there's a problem with a patient, or you need nurse representation I will tell [our IPCC] and she will be able to represent me and I think if it was absolutely vital that I was there or one of the nurses was there we would obviously try and get there, but I just feel that you know its not always the best use of our time. I mean there's no point in having [the IPCC] there who is perfectly able to say if the patient could do this, that or the other, and me as well. (Ward manager, 21060N, FG)

To summarise the impact of the IPCC role on interprofessional working, it is clear that the role was highly valued by many of the IPCCs' interprofessional colleagues. This is in spite of a sense by many interviewed that they did not fully understand the role or who does what in discharge planning, although their understanding had grown over time. The role had altered the patterns of communication between team members. Some team members saw this as an advantage, while others saw this as a disadvantage. The role had also reduced the input that nurses had into some interprofessional team activities. Interprofessional colleagues identified few disadvantages to this practice. Nurses generally saw this practice as positive, given their responsibilities elsewhere, but no systems are apparent from the observation data that ensured clear communication between nurses and IPCCs.

These findings reflect that the IPCC role has had an impact in a number of ways on interprofessional working. The findings in the previous chapter and in this section also point to the importance of examining some emerging issues that may impact on patient care, particularly the competency of the IPCCs in what they do and where the accountability lies for their work. The role shift into work previously undertaken by registered nurses, the liaison role the IPCCs have taken on within the interprofessional team and the key role they play at the weekly

interprofessional meetings have different implications for the impact on patient care depending on the level of competency of the IPCCs. Similarly, an indication that nurses and IPCCs do not have communication systems in place to enable the substitution at the weekly interprofessional meetings, the confusion noted by some practitioners about who does what and the leadership and decision-making elements of IPCC work signal the importance of looking more closely at their regulation and supervision, and the impact of these arrangements on patient care.

The next section examines the impact of the role on patient care, in particular focusing on these issues of competency and accountability.

6.2 Impact on patient care

Many of the IPCCs' interprofessional colleagues identified positive benefits to patient care from the role.

> The flexible boundaries to the [IPCC] role are an advantage as they allow gaps in patient care to be filled that may not otherwise be filled. (Focus group consensus statement, 15020I)

> I think patients get a better deal seeing the system with [the IPCCs] in place. (Nurse, 28049, Int)

> [IPCCs] have a positive impact, if it means people are stopped from slipping through the net. (Speech and language therapist, 07128, Int)

In addition to the value attributed to the IPCC role by their interprofessional colleagues, interview accounts and observations also reflect that the IPCCs' managers highly valued the role. Managers attributed at least a part of a significant fall in the average length of hospital stay and in the number of patients whose discharge was delayed for non-clinical reasons to the IPCCs. Trust reports from this period show that the number of patients whose discharge was delayed decreased from a maximum of 40 patients at any one time (winter 1995-96) to a maximum of 15 patients (winter 1998-99), and the directorate average length of stay fell from 8.5 days in 1996 to 5.9 days in 1998 (excluding patients whose length of stay exceeded 50 days). The improvement in both these indicators was attributed by managers in large part to the introduction of the IPCC role.

As explained at the close of the previous section, in order to fully assess the impact of the role on patient care, it is helpful at this stage to look at the findings that emerged in relation to IPCC competency and the regulation and supervision of

their work. For both of the following sections, the views of the IPCCs, their managers and interprofessional colleagues will be explored in the first instance. This means that, in both sections, the use of interview and focus group data predominates. In the final section of the chapter, the observation data are used as prompts to researcher reflections on the accounts of these participants.

6.2.1 *Common sense skills valued but some doubts about competencies*

This section presents the accounts of IPCCs, their managers and interprofessional colleagues on the levels of skill and knowledge held by the IPCCs. It illustrates that while IPCCs and their managers were confident that no formal training was required to become an IPCC, some interprofessional colleagues had concerns that the IPCCs were not competent in all the areas they practised in. This, they reflected, had adverse consequences for patient care.

As noted earlier, while the lead role in discharge planning had previously been carried out by someone with a professional qualification (usually a nurse), such a qualification is not a requirement to be an IPCC (and none of the IPCCs held such a qualification). The IPCCs shared a similarity in work background, usually having held an administrative and/or support worker role before becoming an IPCC. No formal training had been provided for the IPCCs since their initial induction in spite of recognition that the scope of the role had changed markedly since it had first been introduced.

6.2.1.1 *IPCCs and managers: training not required*

The previous chapter illustrated the complexity of the discharge planning work that the IPCCs were undertaking. However, the IPCCs and their managers shared a view that training was not needed for the IPCC role. The IPCCs felt that their life experience and 'common sense' were more important to their performance in their job than any qualification.

> I think this hospital is lucky in getting the people that they've got. I mean between us we've got about 30 years service within the hospital. We have all come from different avenues, all worked our way up from lower grades up to higher grades, all gone through different departments and we can all help each other through the different fields that we pass through…We don't feel [the IPCC role] would be appropriate for a younger person, somebody that has never ever worked within the NHS or within a medical environment and to fetch somebody in who has been working in a

stockbroker's and put them in the ward, we don't feel that it would work, I think you need a more mature person in the role but I do think that the Trust has been quite lucky with the people that they have actually brought in to do this particular role, because of the amount of experience and the amount of years that we have all had here at the hospital (IPCC, 15020I, FG)

The job that we do we don't necessarily feel that we need a piece of paper with exam results on. Because a lot of our job is based on common sense and good communication and it's discussed at length and good liaison and getting on well, good relationships built with the multidisciplinary team (IPCC, 15020I, FG)

The IPCCS felt their working experience in the hospital was relevant, but also their life experience, expressed by them in terms of maturity and common sense. The IPCCs and their managers did not feel that any kind of formal training was needed to undertake this kind of work.

I don't think they are doing anything they shouldn't be doing, I think they're equipped with enough information, you know, I think they're not making decisions about people that depending on them understanding about the clinical condition, so personally I don't see it as an issue at all. But I think that's the thing that lends them more to the sort of traditional discharge coordinator's role if you like, because the decisions they are being asked to make are fundamentally about planning, rather than diagnosis and treatment. (Manager, 11128, Int)

Implied in this quote is the view that only work involved in clinical diagnosis and treatment requires training. There is also an assumption that discharge planning work can be separated off from clinical aspects of care, that is aspects related to medical diagnosis and treatment. The work that IPCCs did in discharge planning was not viewed as clinical and therefore (on the assumption used by managers and IPCCs that only diagnostic and treatment work needed formal training) did not require a level of skill or knowledge beyond hospital administrative experience and common sense.

There was a sense in which skills and knowledge were also perceived to accrue through experience in the job. Their manager stated that training for the individual post-holders was redundant because all of the IPCCs had been in post for at least a year (and, in most cases, far longer than that). It was felt that their experience on the job had led to them learning what they needed to know and a formal training course at this stage would not add to their abilities. This view seemed to result from a general reluctance by most of the IPCCs to consider any additional training.

They've got no interest in doing it. Perhaps a couple of them think they do it already, they are a bit too old and people don't want to do it. You know, it's a lot of work. But at the same time, people have their own commitments outside of work…if there had been complaints or somebody was under-performing then I would have turned round and said you have to do this course, you know. If one of the members had a particular problem which we thought we could address through doing that course then that would have been an ideal way to actually deal with that. (Manager, 13070: 819-831)

In taking this view, the IPCCs' managers implied that, although the IPCCs had a different training background to registered practitioners, the skill and knowledge levels of the IPCC were sufficient to have no adverse impact on patient care.

6.2.1.2   Interprofessional colleagues: competent in some aspects but role flexibility problematic

Some interprofessional colleagues supported these views that the IPCCs were competent in their work:

You've also got someone who's going to be far more effective at co-ordinating these sort of things because that's what they do, they get into the habit of it and they know who to contact, how best to contact, how things are arranged and when there are sort of managerial aspects to how to arrange things, they will be used to that. When you are a doctor, you are not taught those managerial things and that's new. You learn as you go, but you go slower and do it far less so you make more mistakes. (Doctor, 15049, Int)

I think from a nursing point of view, I think that they're very good regarding any sort of diagnosis or medical jargon or whatever that they're not familiar with, they'll ask us, and I've always had that arrangement with them. (Nurse, 15049, Int)

Not all of the IPCCs' interprofessional colleagues shared this confidence in the IPCCs' competence.

[IPCCs] can maybe take on roles inappropriately. For example, in their role of screening for the need for referrals, they may miss people or things that are important, for example, cognitive problems. Sometimes referrals can be wrong. We've had a lot of referrals recently for 'mobility', this is probably because there is incomplete understanding of OT role. (Occupational therapist, 19019D, FG)

There were two main areas of concern identified in relation to IPCC competence and it was social workers in particular who raised these issues. The first concern was in relation to the direct work the IPCCs did with patients.

I guess my one concern would be their dealings with families and patients directly. I think that that sometimes the focus gets lost - thinking that people come in in such a vulnerable state and in my experience people tend to think that [the IPCCs are] social workers but not all the responsibility lies with them. The patients tend to grab on to whatever they see and do hear things incorrectly that is not necessarily anyone's fault or fixable. But I think it's a dangerous ground when you're asking [the IPCCs] to cover such a wide area and they're coming from anything - when we're talking today about interpersonal skills I think it's dangerous to put somebody in such a position when they don't have any of that training. (Social worker, 09039, Int)

I don't think the [IPCC] is qualified to assess a patient for social needs. They make assumptions. For example, about Bengali families and their living circumstances. What about confidentiality, do they know about that? As the social worker, we have been trained to undertake that sort of assessment. It takes a particular type of person and mannerism. (Social worker, 24118, Int)

The second area of concern was in relation to the flexible boundaries of the IPCC role. Because the IPCCs had no defined scope of practice that was apparent to their interprofessional colleagues, the competencies required for the role could not be clearly set out.

A general need was expressed for the scope, boundaries, working processes and standards of the IPCC role to be clarified and formalised. This may not necessarily mean changes of practice for the IPCC, but would be an important way of reassuring interprofessional colleagues about the competencies associated with the role, for example, OT referrals. (Focus group consensus statement, 15020F)

[IPCCs] don't have a professional framework. As a social worker you are trained to do assessments. You know what you're assessing for; you're applying theories to establish a rapport with the patient and to assess for needs. If you are communicating with vulnerable people you need communication skills. You need to know why you are doing what you are doing. You need to understand your role, the boundaries of your role, to put purpose to your work, to back it up with a body of knowledge. (Social worker, 12118, Int)

This is an important consequence of flexible roles and an addition to the body of knowledge in this area where little is known about what the issues are to do with the characteristic of flexibility. It is impossible to fully specify the competencies needed for a role if the scope and boundaries of the role are left deliberately flexible. It is perhaps inevitable with such roles that, on occasions, practitioners will practise beyond the scope of their previous skills and experience. In the

IPCCs' case, they had no former skills or experience in patient care on which to draw, beyond what they had learned 'on the job'.

Social workers interviewed indicated that there were problems with IPCCs 'over-stepping the mark' and that these had consequences for patient care:

> Because I don't see the [IPCC] remotely giving care that's going to life or death affect them, medical care or nursing care. But then, saying that, big decisions about placements and things, I think that they are huge life changing decisions and I think if they're messed up, that affects patients and that would concern me greatly. One case that I remember is when the nursing staff communicated something to the [IPCC] that this person needs residential or nursing placement, and the [IPCC] - to try and get that going - actually met with the family, said "Why don't you go and look at these nursing homes?", gave them a list or suggested a few, the family went to have a look, came back and said "We like this one" - that's a long way down the process, really. That irritates me. I remember that they'd looked at nursing homes when the person actually needed residential [care], and that's awful. I think what the [IPCCs] don't understand is, you really do have to deal with that, and patients and relatives are furious, absolutely furious, and then they don't want to speak to you. (Social worker, 09039, Int)

> And I do think that when you work in the medical field, you learn so much, and no doubt the [IPCCs], like me, I've learnt so much about medical and nursing stuff that I never used to know. But it scares me to think that they – it's hard to say, but sometimes I think that maybe they think "Well, now I should make that decision" and yes, you've got a lot more knowledge than you used to have, but you're still not a nurse, and I do think that sometimes happens. I used to get information saying "Well, they're really confused" or assumptions made or "they're an alcoholic so they've got Korsakoff's" or something. You don't know, and things are not that simple and that used to scare me a little bit. (Social worker, 09039, Int)

It is not known why it was that social workers raised these issues and not other interprofessional colleagues. Early data collection had revealed tensions between the IPCCs and social workers that were not apparent between the IPCCs and other team members. It may be that these tensions prompted the social workers to speak more critically about the IPCCs. Or it may be that the social workers were more often at the receiving end of IPCC mistakes than other team members.

In summary, the IPCCs and their managers were confident that training was not needed for the role, and implied that in this regard, that there was no negative impact on patient care. The work of IPCCs was viewed as not clinical and therefore not requiring training. In contrast, social workers in particular felt that

the flexible boundaries of the role and the degree of patient contact were problematic in terms of IPCC competency. The inherent flexibility of the role meant that the competencies could not be easily defined. Social workers felt that these issues impacted negatively on patient care. These findings highlight how defining knowledge and skills for a particular task is not clear-cut at all, and is dependent on how that task is interpreted.

6.2.2 Clear managerial accountability but lack of clear professional accountability

This section explores the regulation and supervision of the IPCC role and the impact of these arrangements on patient care. The IPCCs were relatively autonomous in the work that they did. Their managerial accountability was clear (despite frequent changes to their managers – see p.7). During the first part of the study, they reported to the operations managers. During the second part of the study, they reported to the senior nurse. However, their position and uncertain status in relation to the interprofessional team meant that their professional accountability was not clear. In terms of impact on patient care, this meant that no-one took responsibility for supervising them in their work with patients, and that patients did not have a clear avenue for professional redress in the case of poor conduct.

6.2.2.1 Managerial accountability clear but supervision minimal

The IPCC job description reflected that they were responsible and accountable to the operations managers (or, later in time, the senior nurse). All interviewees and focus group participants knew who the IPCCs were managed by. The IPCCs' managers reflected this responsibility in the interest they took in the role, and in the lead they took in management tasks such as appraisal.

> I have just now IPR'd[28] them all and they all get job satisfaction from what they do. One of the key things they find satisfying is their interactions with patients and relatives. (Manager, 15070, Int)

The IPCCs' managers reflected that the one formal check of IPCC performance was at the weekly meetings with their manager where they discussed the detail of patients whose discharge had been delayed beyond clinical fitness.

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[28] Individual performance appraisal/review.

They will come to me for advice if they need it but you know, as they develop their skills and have got more experienced and just encountered the situations more than once and even amongst themselves, they can overcome a lot of the problems themselves very easily with a bit of minimum support. Although sometimes, I have to be truthful, I don't see them from one Friday to the next. (Manager, 15070, Int)

What we do with the [IPCCs] is we monitor them by meeting them weekly and by getting them to specify what patients are delayed, you're sort of checking that the outcome is the same for all of them even if their methods for getting there are slightly different. (Manager, 07059, Int)

The IPCCs' Managers trusted them in the work that they did and allowed them a great deal of autonomy.

Some of it does go on trust and that could be difficult, if you didn't trust them…I think managing them does take a flexibility of mind and a trust that they are getting on with something. (Manager, 11128, Int)

These accounts by managers indicate that they did not supervise the IPCCs closely. The weekly meeting was used as the main performance check for how the IPCCs were doing. Their managers clearly did not see a role for themselves in directly assessing the IPCCs in their daily work.

6.2.2.2 *Professional accountability to nursing claimed but not clear*

In spite of the fact that they were now engaged in work that had previously been carried out by practitioners with a professional training, the IPCCs did not have a clearly specified line of professional accountability in their job description or elsewhere. This was a function of the role's flexibility and was problematic for some colleagues whose accountability functioned within a unidisciplinary structure:

Social Worker: What's their accountability like? Who are they accountable to - do they have any accountability? Do you see that as a problem though, or not?

IPCCs' Manager: Well, it depends where you see the role. If you see the role as being administrative, then there's hundreds of other roles similar in terms of accountability. The difficulty is that there is boundary problems encroaching into professional boundaries - that's what we've got to try and work at getting right. (Focus group extract, 05039A)

IPCCs described themselves in a support role to a range of professions and therefore did not fit into any one of the current groups of registered staff:

I suppose I feel like when I introduce myself to a patient I will say 'I'm [name], I am the care co-ordinator for the team of doctors that are looking after you'. That is what I do, that is what I am employed to do. Nurses phone and I go up and they give me referrals, so I am working for them as well and the social worker that I work with she will phone me up for information. Although that is how I perceive my role as working through that particular team of doctors I don't see that I just work for them. (IPCC, 07128, Int)

This lack of fit with traditional groupings is a key reason for the lack of clear professional accountability. Registered workers are accountable to the public through their registering body for the quality of care they deliver and for the quality of care delivered by individuals to whom they have delegated work. Firstly, it is unclear whether or not the work that IPCCs carried out could be classified as delegated. The findings described in the previous chapter that the nature of IPCC work included leadership over interprofessional colleagues and independent decision-making challenge the notion of IPCCs as simply taking on delegated work. Secondly, the lack of clear accountability to just one staff group makes defining their ultimate professional accountability problematic. Thus, the position and uncertain status of the IPCCs in relation to the interprofessional team meant that their professional accountability could not be clearly specified.

In relation to discharge planning, Trust policy names nursing as responsible for discharge planning. In their interviews, the IPCCs reflected accountability to nursing in discharge matters:

From a care co-ordinator's point of view, I mean although obviously we work with all the professionals, you know, physio, social worker, OT, and obviously the nurses on the ward and the nurse that's actually in charge of that patient's care. I mean at the end of the day, we don't do anything that isn't documented or communicated or passed on to the ward, and the particular nurse or person that's in charge of that ward. So at the end of the day, the actual patient discharge would be down to that nurse who's actually looking after that patient, because we would have forwarded all the information we've got onto that person, whether it be services have been set up by the social worker, OT's been in and, you know, and that we've actually been given the final say that the patient's able to go, and we've re-instated services or sorted out the transport, etc. So the accountability on our part would be the actual nurse that's looking after that patient, you know, the actual person. (IPCC, 15020F, FG)

This view was backed up by the managers, but there was doubt expressed that nurses understood their responsibilities in this regard:

They report to the senior nurse for their overall work but it's a combination. They don't report to the senior nurse every day on what they've done but they report to the ward nurses about their role but I'm not sure that the ward nurses understand their role properly. (Manager, 15020G, FG)

Some nurses supported the claims made by the IPCCs:

A lot of [the IPCC] roles are things that were traditionally nurse responsibilities in terms of co-ordinating, being a lynch-pin, all those things, but from the way I've seen the scheme work with [the IPCCs] I've worked with, they've never approached a patient without involving a nurse prior to that and they are always really sensitive to the fact that you're nursing that patient (Nurse, 28049, Int)

One ward manager, however, did not feel comfortable about being held accountable for the work of the IPCCs, while a staff nurse interviewed was not clear where her responsibilities lay in relation to their work.

In the recent nursing discharge policy that the hospital has authorised, one of the very first statements and one of the biggest problem areas, it says that the named nurse is responsible for the co-ordination of the patient's discharge, and that's where the problem area comes. How can we be responsible for the co-ordination of the patients' discharge if we do not have access to the levels of information which the IPCCs have? What I'm saying is how can we be responsible for something we are not actually doing. We are not doing the discharge co-ordinating any more so how can we be responsible for it. [The IPCCs] are doing a good job of it but we are being held accountable for it. (Nurse, 15020F, FG)

Researcher: Are there situations where the IPCCs are collecting social information, maybe on your behalf. I mean do you then feel the need to verify that?

Nurse: Um, No I don't feel the need to do that, but I don't know if I should or not, but possibly I should (*laugh*). There would be, sort of no point and that would kind of nullify their assessment (11059, Int)

So the claims by IPCCs that they were accountable to nurses for discharge planning matters were not supported by all of the nurses interviewed. In addition, managers felt that nurses may not understand their responsibilities in this regard. If nurses did not recognise the accountability they held, it seems unlikely that any responsibilities that accountability might bring would be recognised by these nurses. These responsibilities include ensuring competency for delegated work. It is clear that at least some of the nursing staff did not feel a responsibility for

supervising the IPCCs in their work. This may have had an impact on the quality of care received by patients.

The flexibility attributed to the role of the IPCC had pervaded so far that it seemed down to individual IPCCs and nurses what arrangements they made for ensuring the quality of care. This flexible attitude, responding as necessary to each episode as it arises perhaps represents the ultimate in policy guidelines that encourage flexibility. However, it also undermines other government aims to make health care practice more transparent, consistent and accountable.

The lack of clarity about the IPCCs' professional accountability that resulted from these arrangements had a potentially significant impact on patient care. Firstly, no one had taken responsibility for professional supervision of the IPCCs, and secondly, patients and families had no avenue for professional redress in the case of poor conduct of an IPCC.

The next section uses observation data to re-examine manager and practitioner accounts of the issues of competency and accountability, and to further explore the impact of the IPCC role on patient care.

6.3   Researcher perspectives

The observation data merit a closer look for two important reasons. Firstly, there is no evidence of anyone else reflectively observing the IPCCs in their work, particularly in their interactions with patients and families. Secondly, as a registered nurse who is highly qualified and experienced in acute care for older people, it may be that I have something to offer that is additional to the perspectives of the other participants. Observation data will therefore be used in this section to prompt reflections on staff accounts of IPCC competency and accountability. Conclusions from these reflections on the overall value and impact of the IPCC role will then be drawn.

6.3.1   IPCCs working as independent practitioners

The observation data support the IPCCs' managers' claims that day to day the IPCCs worked autonomously. They met with their manager weekly and requested additional meetings if they felt these were needed.

> Present at weekly meeting between IPCCs and manager: operations
> manager, 3 IPCCs, myself. Also social work team leader here from

neighbouring borough [Borough B]. The purpose of her attending meeting was to update on policy changes in Borough B and to see if communication had improved between the IPCCs and social workers from [Borough B]. Meeting began by reviewing individual patients whose discharge was delayed beyond clinical fitness - IPCCs updating on their progress with these patients. Common problem identified through these discussions: relatives changing their mind about what they want. Operations manager then asked social worker if there was anything that the IPCCs could be doing differently or better. Social worker said no, now she understands the system here and the role of the IPCCs. Exchange of information on what Borough B funded, eligibility criteria and availability of services over Christmas period. (Field note extract, 13118: 1-37)

In senior nurse's office catching up with her when one of the IPCCs came in to let the senior nurse know how she was handling a 'difficult' family. (Field note extract, 13089: 8)

The observation data also show that the IPCCs' work, particularly their interactions with patients, was not closely supervised. One could argue that, in their interactions with managers and interprofessional colleagues, there was a quality check present in the form of a fellow practitioner. However, the observation data reflect that, in the vast majority of cases, IPCCs worked alone in their direct interactions with patients. These interactions often took place at the patient's bedside, usually geographically removed from other staff members.

IPCCs and their managers stated that the IPCCs were professionally accountable to nurses for the work that they did in discharge planning. This accountability to nurses, however, is mostly not reflected in the practice observations. Although the IPCCs worked collaboratively with nurses on some patient discharges, and accepted referrals from nurses, IPCCs also selected other patients they felt they needed to see and, as illustrated previously, with all patients they decided on the nature of IPCC involvement. IPCCs filtered information to nurses based on what they thought they needed to know, screened and initiated referrals to social work and occupational therapy, and varied considerably in the extent to which they approached nurses prior to and following patient involvement.

Following the interprofessional meeting, I commented to IPCC that there had been no nurses present and she said that was common. She said there was nothing that had come up that nurses needed to know, or she would have told them. She said that one of the nurses was on same team's ward round this morning so presumably knows about discharge dates, etc. (Field note extract, 23089: 248-52)

> Onto admissions ward. IPCC asked nurse if there were any referrals for her, the nurse said no. IPCC checked through Kardex for newly admitted patients. She selected a patient to go and see. After asking him some questions, she explained to him that she would ask the social worker to come and talk to him. Afterwards, she also told me she would be making an OT referral given his general difficulties managing at home, the stairs up to his flat and the stairs within his flat up to his toilet. We left the ward. (Field note extract, 12089: 132-57)

My field notes reflect that there was no system agreed between the IPCCs for documenting what they did. Two IPCCs wrote in the nursing documentation, while the other two did not. In addition, the IPCCs kept their own unstructured records, in one case on scraps of paper kept at home, or in notepads not retained by the Trust.

In spite of the fact that IPCCs were not ward-based, no systematic methods were in place for communication between IPCCs and nurses, and nurses were not observed ever supervising the contact that IPCCs had with patients and their families. Nurses were rarely seen to directly delegate work to the IPCCs. These observation data do not support the view that IPCCs are carrying out delegated work for nurses. They also challenge the IPCC job description which described the IPCCs as administrative support workers, and the Trust discharge policy which names nurses as the lead group in discharge planning. The IPCCs were, in fact, working as independent practitioners. This finding raises new implications for the regulation of IPCC work, as much of current professional regulation is based on protection of existing professional titles, rather than protection of particular spheres of practice. This means that new occupations are not currently under the umbrella of existing regulatory professional legislation. This includes the IPCCs.

6.3.2   *Skills and knowledge beyond clerical competency*

In the previous chapter, interview and patient profile data were used to illustrate the complexity of the discharge planning work undertaken by the IPCCs. Earlier in this chapter, we saw that the IPCCs and their managers did not believe that training was required for the IPCC role. Social workers, however, had concerns about IPCC competence particularly in relation to direct working with patients and the flexible boundaries to the role. This section builds on these finding by using observation data to illustrate the level of skills and knowledge that the IPCCs possessed for this work.

The perception of the IPCCs and their managers that their skills and knowledge could be expressed merely in terms of life experience and administrative experience in the hospital does not stand up when compared against the observation findings. For example, the following illustrates an IPCC's assessment of a new patient.

> Went to see patient (Mrs E[29]) and daughter on Ward 7. Asked patient what services she had. Personal care in the mornings 7 days a week. IPCC asked if she thought she needed it in evening. Also has one hour of home help per week. Patient said home help was variable, sometimes not good. IPCC said it was up to patient to complain. IPCC asked what about shopping, patient said daughter did it. IPCC said if more input were needed, they should let her know.
>
> IPCC found out that patient has trouble getting in bath. She has bath board and seat but still difficult to get out of bath. Daughter does cooking and IPCC asked how patient would cope with that if/when daughter leaves.
>
> IPCC suggested they need to get Borough E to re-assess. She also suggested getting a microwave and getting frozen meals-on-wheels. Daughter going away for a few weeks, IPCC didn't know if meals-on-wheels were provided short-term. IPCC suggested microwave because patient wouldn't be safe bending over to use oven. IPCC: 'Perhaps you need to think about these things'. IPCC asked if patient had seen occupational therapist (OT) during recent admission to [Trust's other hospital] - she had not. IPCC said she would refer to OT for assessment while patient was still an in-patient. Started filling in form. Invited patient to ask the nurses for her if she thought of anything else. (Field note extract, 23089:125-145)

In my view, the nature of this assessment reflects not only common sense, but also a high level of skill and knowledge. In this interaction the IPCC is using highly developed interpersonal skills to sensitively question a patient and her daughter about her home needs. The line of questioning was revised in the light of emerging information and answers were interpreted to indicate what support that patient might require on going home. The skills involved here are interpersonal (gently probing for information and making suggestions), interpretation (using knowledge of mobility status to suggest cooking arrangements) and decision-making (using information gathered to decide OT assessment needed). A wide breadth of knowledge about coping abilities, family care and community services is also evident.

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[29] Name has been changed.

The field notes also reflect many other examples of IPCCs using high levels of skill and knowledge in the discharge planning work they did with patients. For instance, their frequent practice of adding information to that already documented by nurses on social work referral forms suggests a level of expertise that is, in this domain, at least as good as many registered nurses:

> Following her assessment of Mr C[30], the [IPCC] retrieved the social work referral form that the nurses had filled out. They had given the following reason for referral: 'Assessment of housing situation. General social services'. [IPCC] added: 'Has recurrent falls at home. Has no social service input at present, but did have them in the past'. (Field note extract, 10089: 38-42)

In the above extract from the field notes, the IPCC was able to supplement the general request made by the referring nurse with pertinent and specific information that she had gathered during her assessment of Mr C.

In another example, a man who had been admitted previously to the hospital with a stroke had been discharged to a rehabilitation unit and had then been discharged home. After one week at home, he had a further stroke and was admitted back to the hospital. Knowing how long the waiting list was for the rehabilitation unit, the IPCC independently contacted the rehabilitation unit he had been on to see if they would take him back following his acute stay.

Field notes also reflect a case in which an IPCC's clinical knowledge and observations led to a decision by the interprofessional team to delay someone's discharge to ensure that he was well enough:

> House officer: [Patient B[31]] for discharge tomorrow
>
> IPCC: he was very confused when I saw him on the ward this morning
>
> Registrar: we'll have a word with the family. He seemed *compus mentus* to me on ward this morning. We'll do a septic screen[32].
>
> OT: I could get [an OT colleague] to check him out
>
> IPCC: I don't think she could at the moment, she's too busy. If you send him home and the family's not happy, they'll come and scalp you!

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[30] Name has been changed.
[31] Code allocated to patient in field notes and unrelated to patient's actual name.
[32] Tests to confirm or rule out an acute infection that might be causing treatable cognitive impairment.

General agreement to delay discharge until septic screen results come back.

(Field note extract of weekly interprofessional meeting, 19089: 217-223)

The findings that discharge planning requires a high level of knowledge and skills are supported by recent government policy which states that a high level of skills and knowledge are required to co-ordinate patient discharges (Department of Health 2003b). However, the policy also states that such work should only be performed by a registered nurse, or, in some non-acute settings, a therapist or social worker.

In spite of these national policy requirements, the IPCCs are evidence that such work can be conducted skilfully without a registered qualification. However, it is important to emphasise that it was these individuals on this occasion who, by whatever means, possessed the necessary skills. What cannot be assumed is that others without a registered qualification would perform the work as competently.

The IPCCs had taken on discharge planning from nurses but had not received any formal training to undertake this role. This, and the tendency for the IPCCs to call their skills 'common sense' suggests a low value has been ascribed to the knowledge base associated with this aspect of patient care. A perception is implied that physical patient care is more important than discharge planning, and that discharge planning does not really require any training or development.

IPCCs and their managers felt that the IPCCs' work is dependent on their life experience and knowledge of a hospital environment, but the observation work reflected that the IPCCs did, in fact, possess other knowledge and skills. In addition, they worked with patients with more complex needs. In this sense, their work cannot be described as merely clerical, a view that is reflected in their job description and through their true role in discharge planning not being reflected in Trust policy. While these IPCCs on these occasions seemed to possess the necessary skills and knowledge, this does not guarantee that others with a similar lack of formal training would also be competent to take on work of such complexity.

The above examples that illustrate high levels of skills and knowledge by the IPCCs suggest a positive impact on patient care, and lend support to manager and practitioner views that the IPCC role makes a positive contribution.

6.3.3   IPCCs practising beyond the scope of their competencies

This section illustrates that, while the IPCCs' work was clearly valued by their managers and their colleagues, and while they were clearly very skilled in many aspects of their work (see above), some aspects of their work were potentially problematic to patients. Not only had a need for training not been acknowledged in the domain of discharge planning, but the flexibility of the role and subsequent lack of role clarity also meant that the IPCCs could also potentially carry out other work for which they were not trained. This had, in conjunction with the lack of supervision of the IPCCs, led in some cases to a lack of judgement and errors.

Some of the IPCCs' interprofessional colleagues had expressed discomfort because the IPCCs had no defined scope of practice and therefore no defined competencies. This discomfort was mainly related to the patient contact the IPCCs had. The observation data reflect that, in some instances, these misgivings were justified. Two examples now follow of the IPCCs practising beyond the scope of their competencies.

The first example involved raising the prospect of nursing or residential home placement with patients who had previously lived at home. Two occasions are recorded in the observation field notes where an IPCC (a different IPCC on each occasion) raises the prospect of such placement during the initial assessment session. On both occasions the IPCCs initiated this discussion rather than the patient and asked the patient if they had considered going into a nursing/residential home. In both incidents the IPCC seemed very sensitive to the feelings and concerns of the patient. One patient had already had placement in her mind as a possibility while the other patient received what looked like appropriate comfort from the IPCC.

Current guidelines state that 'a new referral for continuing care should only follow a comprehensive assessment of need [by NHS and local authorities with social services responsibilities], in the case of older people, or a joint assessment for all other people, and an evaluation of the appropriateness of other interventions, such

as a period of rehabilitation and recuperation' (Department of Health 2003b, p. 100). Research in this field highlights the importance of sensitive, multidisciplinary assessment and input to anticipate and deal with the significant impact that a transition to continuing care can have for individuals (Cotter, Meyer, & Roberts 1998). This guidance was clearly not followed by the IPCCs. It is possible that such an early intervention by the IPCCs may have been based on faulty decision-making and that placement is, in fact, not necessary. By raising such a topic unnecessarily, there is a possibility of causing undue distress or anxiety in patients.

It is also possible that an intervention like that of the IPCCs here is actually positive for patients and that they felt a sense of relief about being able to talk honestly about their needs. Certainly, when these observations were raised with the IPCCs' manager, she did not feel that there was a problem with the IPCCs' operating in this way.

No one else ever sat in with IPCC discussions with patients. This lack of supervision may well be a result of the unclear accountability structure discussed earlier. The manager's approval of this practice seems an example of an endorsement of the flexible boundaries to the IPCC role but this endorsement was not accompanied by ensuring they had the relevant skill base.

This example raises the issue of how the flexibility of the role may lead to unsupervised and unregulated practice in areas where the skill base has not been well defined. Areas of practice that are less tangible, such as psychosocial care, may be more vulnerable to not being acknowledged and therefore not supported by the relevant skills, or accompanied by the appropriate structures for regulation and supervision.

The second example of IPCCs practising beyond the scope of their competencies shows the involvement of an IPCC communicating faulty clinical information to the relative of a patient. This patient (Mr L)[33] was 19 years old and had been admitted to hospital following an incident that had led to physical disabilities and extreme disturbances in his behaviour. As he was not deemed competent to handle

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[33] Name has been changed.

his own affairs, the interprofessional team had mainly communicated their findings and recommendations for treatment to his mother.

In order to help determine where Mr L needed to go for care following his hospital admission, the IPCC involved had arranged a psychiatric assessment (in agreement with the doctors handling Mr L's care). The IPCC was keen to 'keep things moving' and went to the psychiatrist's office following the assessment to collect the report. The report documented that the psychiatrist had diagnosed 'significant cognitive impairment', a diagnosis that would be devastating for a young man with previously normal abilities. On her return to the ward, the IPCC handed the psychiatrist's report to Mr L's mother (who was sitting with the occupational therapist) with the comment 'I've read it and it's not too bad'. The occupational therapist then offered to go through the report with Mr L's mother and this probably meant (because of training that OTs received about cognitive functioning) that Mr L's mother would then be receiving accurate information. However, if the OT had not been there, Mr L's mother would have either believed the 'false hope' given by the IPCC or, having been given the report to read on her own, would have discovered the disturbing information in the absence of anyone with the knowledge and skills to provide further information and support.

Because the OT was present, the worse case scenario did not happen here and, of course, it is not known whether the presence of the OT led to the IPCC's decision to hand the report directly to the mother. What is of concern though is the lack of negotiation with the OT (or any other team member) as to whether or not to hand the report directly to Mr L's mother or to communicate its contents in a different way. Also of concern is the lack of knowledge the IPCC had to interpret the report and the implicit communication made to Mr L's mother as the IPCC handed over the report that she (the IPCC) was in a position of expertise to be able to interpret that information.

Bearing in mind the level of skill that the IPCCs demonstrated that was illustrated earlier but not acknowledged by IPCCs or their managers, these examples suggest some other skills necessary for good patient care may have also have been marginalised. This has led to some mistakes and situations in which patients may have been put at risk, but adverse outcomes for patients and families in these situations are less easily identified and articulated than, say, a drug error. Poor

attention to the psychological aspects of life-changing decisions or causing distress or false hope through giving faulty information may not put lives at risk, but may be the most significant part of a patient's experience during their hospital stay, and merits an attention to the skills required, though they may be more difficult to articulate than technical skills. In addition, because the IPCCs were not closely supervised, no one (except maybe the IPCCs and/or their patients) was aware of these 'close calls'. An accompanying lack of regulation to these aspects of practice also reduces patients' opportunities for redress.

In summary, the skills and knowledge possessed by the current IPCCs contributed to them having a positive impact on the quality of patient care. However, their work as independent practitioners and the lack of clarity about their professional accountability is problematic. If, as the findings suggest can happen, the IPCCs were practising beyond the scope of their competencies, there were no systems in place to identify or address this unless the patient or family makes a complaint. These findings shed some light on the potential dangers of recruiting individuals into a role for which the competency, regulatory and supervisory requirements are not recognised.

The findings illustrate how the role shift illustrated in the previous chapter had not been accompanied by ensuring that training, regulation and supervision supports were equivalent to those had nursing retained the work. The overall conclusion on the impact of the IPCC role is that these findings reflect that the contribution can be positive but more systems need to be put in place to ensure the quality of care to patients.

6.4   Chapter summary

This chapter has addressed the second and third research objectives, that is to identify the impact of the IPCC role and the issues arising from it. In the first section of the chapter, findings are used to explore the impact of the role on interprofessional working. The impact included making a valued contribution in spite of continuing uncertainties about the role, altering communication patterns between team members and reducing opportunities for nursing input to some interprofessional activities.

In the second section of the chapter, the impact on patient care is reviewed. The role was generally seen to make a positive contribution, although a closer look at issues of competency and accountability raises some important issues. IPCCs and their managers felt that no training was required for the role. Social workers, however, expressed concerns about the competencies of the IPCCs in direct patient contact and about the flexible boundaries to the role. The IPCCs' managerial accountability was clear, but their professional accountability was unclear.

In the third section of the chapter, observation data are used to illustrate that IPCCs were operating as independent practitioners and that they possessed high levels of skills and knowledge that exceeded clerical competency. However, findings also reflect in some instances, IPCCs were practising beyond the scope of their competencies.

The findings in this chapter identify that the role shift that has occurred in IPCC practice had not been accompanied by ensuring that systems were in place to protect the quality of patient care. While the actual contribution of these IPCCs appears to be mainly very positive, the potential exists for negative consequences in the absence of suitable systems for ensuring that competencies match the work carried out, and that the work is properly supervised and regulated.

The next chapter examines the wider contextual influences on the IPCC role and this sheds further light on the context in which the IPCC role and its attendant issues emerged.

7   Contextual influences: turbulent context meant short-term approach to innovation

This chapter addresses the fourth objective of this study by examining the key contextual influences on the IPCC role. Data sets from all phases of the study are drawn from in this chapter, although it was mainly the reflection phase that provided data reflecting on the influences on the role. Data sets used include data from my field notes (total n=110), interviews (total n=37) and focus groups (total n=16).

The previous chapters have illustrated that a shift occurred over time in the IPCC role, and that this shift brought with it new requirements for training, regulating and supervising the IPCCs. As the findings have shown, these new requirements were not met.

In the introduction chapter (p. 8), the development work associated with this action research study was described. This development work included addressing the new requirements for the role that had emerged. This (introduction) chapter also detailed what changed and what did not change over the course of the action research study. It illustrates that while some changes were made (for example, changing the organisation of medical teams to a ward-based system, improvement of relations between IPCCs and social workers, producing business cards and an information pack about the role), no changes were made in the way that IPCCs worked or that clarified any of the issues around their training, regulation and supervision. Some changes in this regard were started but never completed. This was in spite of widespread agreement with the action research findings and participants planning what action they wished to take in response to the findings. This chapter examines why.

Findings in this chapter show that managers operated in a turbulent context characterised by multiple pressures, top-down targets and high managerial

turnover. In addition, nurses did not perceive that they had an influence on the ongoing development of the IPCC role. This finding is further evidence of a top-down culture. These contextual features account for a short-term view being taken of IPCC role development and the scant attention paid to issues that emerged from the role shift.

7.1 Participant agreement with changes needed

As noted above, not as much change was achieved in the action research study as was agreed by participants as being necessary. The goals set within the three action research cycles had been derived through the democratic, participative processes described in the methods chapter and thus can be seen to reflect what participants felt needed to happen.

As they reflected back on the project as it reached its end, participants agreed that the action research study had provided the impetus and opportunity for changes to be made. As they did this, they reinforced how important the goals were that had been set.

> From the workshops, it may have brought attention to a lot of the problems that we had to individuals who didn't listen twice before but may have listened at the workshops. (IPCC, 23060P, FG)

> I think it's highlighted to senior people that if one of us left or the role folded up and they started again or whatever, that they would look into employing people differently…I mean, you know the role's been set, it's working, but obviously any outsiders that are coming into it would obviously go in through another system, so that they wouldn't just be employed like we were. (IPCC, 23060P, FG)

> The really good thing is that the detail and the analysis and taking some of the detail forward has happened which it wouldn't have done, I'm sure, as quickly, and maybe never at all, had the research not facilitated it. For example, [setting up regular meetings between the directorate and the social work department], that meeting was I think really good - successful and we have had our follow-up meeting and I am sure that has improved relations and I think the transition from [one social work team leader to another] has been made easier by doing all those things. (Manager, 07059, Int)

> The action research has made us challenge, it helps us formulate ideas and thoughts. I mean, just the thing about having business cards, it's very practical things. (Manager, 27049, Int)

While some important and drastic changes resulted from the action research study (for example, the change of the medical teams to ward bases, see p. 12), there were still other changes that could have been made that were not made during the course of the study. The remainder of this chapter looks at the contextual influences on action and lack of action.

7.2 Lack of momentum for change

In spite of the number of changes achieved, there was a feeling from some participants at the close of the project that more could have been achieved, and a concern that the close of the project meant that there would no longer be a force for change in these areas. There was a sense from participants that, once the IPCC role had become established, it was difficult to build up the momentum to initiate change, in spite of the fact that the role shift had raised new issues and that participants had agreed on the need to address these issues.

> I think what the action research has done is taken something that had a real danger of stagnating and getting very complacent and a bit stale and made it take a fresh look at itself. I think [the IPCCs] are a very good example of the way things operate in that we have lots of ideas, we get these things started, we're really interested in them to start with and then we move on to something else, and we leave these people to sort themselves out and get on with it. (Manager, 07059, Int)

This notion of putting energy into implementing an innovation, and then moving on to other things is worth noting at this point. As we have seen, the IPCC role continued to change beyond its initial introduction, but managers admitted that their attention beyond the role's initial introduction was taken up then with other matters.

Participant accounts of the role's introduction suggest that the IPCCs were closely supervised by the senior nurse in their practice until they were deemed competent.

> It was quite closely managed at first, wasn't it? There was a lot of input from the senior nurse, when they first kicked off. There was a lot of feedback and a lot of close supervision. (Ward manager, 13049C, FG)

However, as previous chapters have shown, while the role had shifted significantly since its introduction, no further attention had been paid to the need for training, regulation and supervision.

The reason commonly given for the relative lack of attention to the need for change around the IPCC role was the context in which the project had taken place. While the focus of the action research project was seen to be important, there was also a sense from participants of other, more pressing priorities than the issues the action research was focusing on:

> I think action research can change the priorities of an organisation in which it's being conducted and so, as a manager, you have to be quite sensitive to that and be sure that the reason that you're doing that bit of work before another bit of work is for the right reason. (Manager, 07059, Int)

> Somebody can do action research if they've got the resources to do it or the time to do it but also, there has got to be the time to actually do the action that comes out of the research and who does that go to? Who should be doing it?…There is a list of things that I know I should be doing, which has come as a result of the action research but have I got the time? The resources and the rest of it to actually get these things done?…There has got to be commitment to it and I think that you know, there has been commitment to this programme from a wide range of people but I think we are working in a service that is so over-committed already almost you know, and this is what is so frustrating about it really. (Manager: 13070, Int)

The accounts of these other priorities suggest that managerial and practitioner attention had moved on since the introduction of the IPCC role and that it was hard to build the momentum to concentrate on the issues raised in the action research study.

7.3   Turbulent context for managers

This section looks more closely at the contextual reasons cited by managers as to why there was a lack of momentum that meant managerial attention only focused on the IPCC role during its introductory phase. Findings will be used to illustrate how the pressing nature of other organisational priorities meant that there was no capacity for making changes in an area in which only potential problems of patient safety had been identified. Managerial priorities were focused on acute efficiency and meeting other top-down targets for performance. In addition, a high level of managerial turnover meant that a longer-term view of the IPCC role and its development needs had been difficult to sustain.

In their interview accounts, managers cited three main features of their daily working life that were seen as interfering with their ability to concentrate more on

the IPCC role. These were the existence of multiple pressures, of top-down targets (including a key target of acute efficiency) and a high level of managerial turnover. Each of these will be considered in turn.

7.3.1 Multiple pressures on managers

Directorate managers described a context for their work that was complex and demanding, often requiring instant responses to unanticipated situations, or complying with externally set deadlines.

> You have deadlines to respond to complaints for instance, you know you've got to deal with them in twenty working days, you've got things like the Health Quality Service [HQS] Audit that is coming up in September so that to me is a priority. I don't want to be the person reported by the Trust to say we failed the HQS because of general medicine. You are always working to these deadlines and very often these deadlines are very high and they are sort of deadlines that are out of your control. I think very often when you are working to deadlines on and off, or you are responding in general medicine, a lot of work that I do is responding to crisis situations, whether it is somebody's been suspended, whether it is a patient who's absconded from the ward, jumped from a window or nurses have been attacked or something like that you are forever responding to that. And the things that haven't said there's a deadline, things to do with development, always get pushed. There was always something else that needed doing by a certain day. (Manager, 13070, Int)

Findings reflect a service that is running hard just to stand still with multiple competing demands. Both managers interviewed at the close of the project cited the demands of the organisational restructuring, changes in key personnel and the demands of quality monitoring as key factors affecting the degree to which positive change occurred.

> I think [the action research] has moved us on. I think it's unfortunate we had all these changes and the loss of the operations managers and things but that's just real life. Nothing's ever going to stand still for more than a short while…It's just the number of audits and surveys going on which is extraordinary. You're just constantly gathering data and filling in forms and showing people round. (Manager, 06060, Int)

When the IPCCs were managed by the senior nurse, she admitted she was so caught up with other issues that there was little time for looking and acting reflectively on the IPCC role, a role seen to work effectively.

> Researcher: Sometimes a study can draw attention to an area and maybe give it undue weight and priority in terms of the list of priorities. I mean

what do you think about the ideas and suggestions that have come out of this work. Where do they fit in terms of your list?

Senior nurse: I think they are all very, very relevant, you know. And in some ways they are all priorities but, what I suppose is very, very difficult for me is that …I have almost inherited the care co-ordinators. I think that as the senior nurse of medicine, my priorities lie in some ways with the nursing side in patient care and the staff development and recruitment and the complaints and the quality issues and all that, I'm not saying that the care coordinators aren't part of that but that has probably taken a second priority in my day to day world because it is almost like saying that something has got to go. (13070, Int)

The IPCCs recognised this tension as well:

IPCC1: Obviously [the senior nurse] is very good, she does try and put in as much as she can, but she's very busy. And I think really [the operations managers] were excellent. They were there for us, they listened to us, they tried their hardest to get things done for us

IPCC2: I mean they were very focused on the role which made a huge difference, whereas [the senior nurse's] focus is a nursing role (Focus group extract, 23060P)

Here it seems that the range of nursing issues the senior nurse felt primary responsibility for did not include the discharge planning work that IPCCs had taken on from nurses. These finding add to our understanding of the management of new roles. If managerial attention lies elsewhere, there may be insufficient attention the new role as it develops.

A sense also emerged from managers' accounts that, because the IPCC role was generally seen to be successful and working well, there was little need to look more proactively at it. This sense is reflected in the views of the IPCCs' manager on encouraging the IPCCs to undertake further formal training or gain accreditation of some kind for the skills they had:

They've got no interest in doing it. Perhaps a couple of them think they do it already, they are a bit too old and people don't want to do it. You know, it's a lot of work. But at the same time, people have their own commitments outside of work…if there had been complaints or somebody was under-performing then I would have turned round and said you have to do this course, you know. If one of the members had a particular problem which we thought we could address through doing that course then that would have been an ideal way to actually deal with that. (Manager, 13070, Int)

A picture is described here of an organisational context in which change was common and was often outside of the perceived control of participants. Demands were made that required speedy responses, and the time for 'standing back' and looking at development opportunities was constrained.

> For instance, with the winter pressures money[34], they say 'we have a pot of fifty thousand [pounds]. Put your bids in by the end of the week' and you think 'oh my God'…and if you don't actually act in that time, you could be losing out on the pot of money which could improve your service. But that is the way it is going. It is reactive, there is no forward planning.
> (Manager, 13070, Int)

Managers in this study were dealing with multiple issues that competed for their time. The need for, for example, responses to a large number of pressing concerns was seen as interfering with their ability to deal with other issues such as IPCC development needs.

7.3.2 *Top-down targets*

One key source of pressure for managers was the need to meet 'top-down' targets on a range of matters. The language used by managers indicated that these targets were imposed on them and that there was no choice in the degree of importance attributed to them. One directorate manager described a 'military' organisational culture in the Trust in which she did not feel able to influence more senior members of the organisation and in which the contributions she and others could make were not valued.

> We went on the senior managers development program which was at Sandhurst and it very much highlighted where [the chief executive] was coming from and it was like the curtains opened and we thought "oh now we know where all this is coming from!" because it's, you know the way they manage is you set the mission, give your orders and you let everybody get on with it…But no idea that actually you could use the knowledge of the body because they're used to having the expert at the top, you know the information comes in from outside, the experts decide how to deal with the information and then they tell the troops what to do, whereas in an organisation in my mind the experts are actually at the bottom because they're the ones doing the work, the clinicians etc., but they were not consulted, how can we change an organisation without consulting anybody. (Manager, 07059, Int)

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[34] A fund distributed through the regional health authorities designed to relieve the pressures on the acute sector over the winter period. Trusts were invited to submit bids to the fund to develop services for over this period. In both 1997 and 1998 invitations for bids were advertised with notice of typically 2-3 weeks, sometimes less.

This 'top-down' culture was reinforced by organisational imperatives to meet a range of government targets.

> There are always different things coming up within the Trust that have an influence, an input on the way you work and I think the thing that is keeping you down around the Trust at the moment is about the traffic lights[35] that have come in and we were one of the worst performing Trusts in the country…and some of that is to do with the way beds are managed and that sort of thing which there aren't any easy answers to and they need a lot of work on. It has certainly affected the way some of the directorates are working. (Manager, 13070, Int)

The need to achieve and maintain acute efficiency was the government target most often cited by directorate managers and it is this target that is focused on in the following section.

7.3.2.1 *Key target of acute efficiency*

A key demand cited by directorate managers was the need to achieve acute efficiency through keeping patients' length of stay as low as clinically possible.   It was clear from directorate managers that it was the Trust board driving the agenda here, influenced by government targets for acute efficiency.

> Our drive, if you look back, although we maybe had a vision about what we wanted to do and what we wanted to achieve, our drive was that the executive board stated that our length of stay was unacceptable, it was too high. So we had a very tangible target, that was very managerially set out. (Manager, 27049, Int)

This demand was often what focused staff's attention, and, although the directorate staff felt they were managing as effectively and efficiently as they could, pressures remained high:

> The fact that the Trust now recognises that our length of stay has come down so much, and they recognise that it would probably be unsafe to make it go any lower, is actually real recognition. I think that's phenomenal. (Manager, 27049, Int)

> We've seen our length of stay come down to the length of stay that we should be at. The statistics all say that [the directorate] is working effectively and efficiently as it can and I think that is the feeling throughout the Trust. You know, when they talk about problems with beds

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[35] A national ratings system introduced by the Department of Health in 2000. Trusts were rated against a range of measures to the following scale: red (worst performers requiring direct intervention from regional offices and the Modernisation Agency), yellow (average performers to be forced to be more accountable) or green (best performers to be given more freedom and money to spend).

and discharges, it is never [this directorate] that comes up because they know that we are doing everything that we can, but at the same time, we can't tell how many patients we are actually going to have coming in each day. It is that unmanageable workload. If it turns out one week that we have thirty admissions every day...we would be stuffed. You can't manage that sort of thing. If we ever had thirty admissions every day, day in, day out. If that scenario ever happens, I don't know what will happen. And it almost feels it could be a reality. (Manager, 13070, Int)

It is clear that helping to achieve this acute efficiency through discharge planning was a key driver behind the IPCC role.

[The IPCCs have] got me every week, saying 'why is this patient still here, why haven't you done that?'. That's my job to get people out of hospital, and therefore that is part of their job. (Manager: 05039A, FG)

Manager: What the core of the [IPCC] role is shouldn't differ between them and that's what you got to try and get to grips with in your head and that's what you can't lose sight of.

Researcher: Is there a core?

Manager: Well I think the only way you can monitor that is by these weekly meetings so at the end of the day my objective is to ensure that there is nobody in this hospital longer than is currently necessary. And, if every week they can produce a valid reason for why they are all here and no reason why they shouldn't be here then they're achieving that objective and that's the core. (Manager, 11128, Int)

The shift of the IPCC role to discharge planning was attributed to the need for acute efficiency:

So I think that emphasis [of IPCC work on the whole inpatient stay] has gone and I think that is an emphasis which has probably come to us just the way the health service is running at the moment, that you need the beds and the only way to have empty beds is to make sure that you are discharging people timely and effectively. (Manager, 13070, Int)

Interview data reflect that the IPCCs were viewed by their managers as making a significant contribution to a decreasing average length of stay in the service and a reduction in the number of patients whose discharge was delayed for non-clinical reasons (see previous chapter). The primacy of the need for acute efficiency was reflected across the NHS at this time (see p. 19) and it is perhaps unsurprising that managers were reluctant to interfere with a role that was seen to successfully contribute to achieving this.

The findings thus far indicate that the daily pressures inherent in running the service, including the need to meet top-down targets were inhibiting managers' ability to feel in control of their priorities and actions.

7.3.3   High turnover of managers

A further contextual influence was the number of times the IPCCs' manager changed. In the four years between the role being introduced and the action research study ending, the IPCCs had five different managers[36].

When the role was first introduced in 1996, the IPCCs were managed by the directorate's senior nurse. After a few months, their management was reviewed and taken over by the directorate's two operations managers (who job-shared the operations manager role).

My field notes reflect that in 1999 the whole Trust restructured its management arrangements and the operations manager posts were eliminated. Two months before the proposed restructuring took place, both operations managers left the Trust to take up new appointments and an interim operations manager was appointed until the new management arrangements took effect. The senior nurse initially held the interim post until the official interim post-holder took up post.

Following extensive debate about who would be best to manage the IPCCs in the new organisational structure, it was eventually decided that the MED senior nurse (who had also served as the first interim operations manager after the original operations managers had left) would manage the IPCCs. By this point in time, this (senior nurse) post was held by a different individual to the one who had originally managed the IPCCs. As the organisational restructuring had also included an expansion of the directorate to include accident and emergency and the specialist medical wards, the senior nurse post now had a wider remit than previously. At the close of the study, this senior nurse left the NHS and the IPCCs were about to take up their sixth manager in four years.

Given the high turnover of managers, it is perhaps no wonder that the need for examining the implications of the role shift was not taken on by any single individual. As a manager, it must be difficult to stand back and take the long-term

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[36] This figure does not reflect the job share of the operations manager post between two people.

view if you yourself have not been in post for long and are continually responding to shorter-term priorities.

While two of the managerial changes could be accounted for by thoughtful review of who would be best to manage the IPCCs, it is clear that most of the disruption to the IPCCs' management was a result of the wider organisational restructuring initiated by the Trust board in 1999. Some data were gathered on the rationale behind the Trust boards' thinking and these indicated that the board was aiming at a greater devolved autonomy at clinical level.

> The Trust's view is that they are making these larger groups have more autonomy. All the directorates are going to have their little trust boards with these big nice units under them, and they will be autonomous. (Manager, 27049, Int)

However, in spite of the board's intentions, these findings reflect that the process and outcome of these changes had a significantly detrimental effect on the ability of this directorate to keep a long-term reflective view on issues of service quality.

Interestingly, managers who had been in post for longer than average made two of the most significant changes in the action research study. Early exploration phase interviews with social workers had identified that social workers had concerns about the IPCC role and felt that social work goals with patients were not well understood by directorate managers who seemed focused entirely on discharging patients quickly. The operations managers set up and facilitated meetings with social workers that led to a general improvement in relations between the directorate and the social work department. This was evidenced also by a noticeable improvement in the quality of relationships between individual IPCCs and social workers.

> While carrying out the observation work in August 1999, I was struck at the positive relationships between the IPCCs and their social work colleagues. Social workers frequently dropped into the IPCC office to exchange information or discuss a client. Interactions were warm and friendly, and there seemed a genuine trust in and reliance on what IPCCs did. (Field note extract, 18112: 1-4).

The work to achieve this change took place early on in the action research study before the operations managers had left. By that point in time, they had worked in the directorate for three years (although had not managed the IPCCs for that long) and were anxious to improve relationships with social work, in part to help speed

up patient throughput. Issues about training, regulation and supervision emerged later in the study after the operations managers had left the organisation.

The second significant change that was made was the change in the organisation of medical teams to a ward base in order to improve opportunities for interprofessional working. Study findings during the exploration phase had identified that the IPCCs were making up for a mismatch in the way interprofessional care was organised. While nurses and physiotherapists were ward-based, medical teams organised their input and patient allocation differently. This often meant that each ward had patients from up to twelve medical teams. Social workers attached themselves to medical teams rather than ward bases. These differing forms of organisation meant there were no coherent interprofessional teams with stable membership. This led to instances in which, in the weekly interprofessional team meetings, one of which was held for each medical team, were officially attended by nurses from a number of wards. In practice, nurses were often not represented at all.

The raising and consideration of this issue during the study led to a change in the organisation of medical teams. The directorate's clinical director who, by the end of the study, had been in a senior clinical management post in the directorate for nine years led this change. By the close of the study, the findings had persuaded her that organising the medical input to the wards in a different way may enable closer working relationships between doctors and nurses in particular, and facilitate the attendance of nurses at the weekly interprofessional meetings[37].

> I went to the directorate meeting this evening at which [the clinical director] successfully persuaded her medical colleagues to ward-base the medical teams. There were some concerns that the change might narrow the range of experience some junior doctors get, or that some wards might end up with all the 'heavy' patients, but once a new system for allocating patients admitted to wards and medical teams had been agreed, most doctors there were willing to trial the idea if there was potential for improving interprofessional working. (Field note extract, 03041: 1-8)

The clinical director admitted that the turnover of managers had been disruptive, and contrasted with her ability to keep some things going, because she had been in post for longer.

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[37] This change was later the focus of a further study to explore its impact on the quality of interprofessional working (Reeves et al. 2003).

> I think during the first year [of the study] the main change was the loss of the operations managers which was scheduled for October 1999 anyway, but happened around May 1999, and then we had a summer where things were slightly disjointed with nobody in the role, and then [the later head nurse for directorate] acting into it but she couldn't actually contribute a lot. Now [the senior nurse] has been put in a more key role as the face of the service which she's done very well. And I have continued as lead clinician, so there were various things that I was involved in that are continuing seamlessly. I think we haven't lost impetus as a result of these changes but I think we're standing still a bit. (Clinical director, 06060, Int)

These findings illustrate how the high turnover of individuals managing the IPCCs meant that a reflective approach to managing the role based on a long-term understanding of the issues that had emerged was difficult to achieve.

In summary, the findings have highlighted a number of features about the context in which managers operated which made it difficult to be reflective and proactive about the IPCC role. The existence of multiple pressures, of top-down targets including the need for acute efficiency and a high turnover of managers had constrained managers' ability to attend to the role once it had been introduced and was seen to be successful and contributing to acute efficiency.

7.4 Nurses didn't perceive involvement in decision-making

In addition to the managers who changed frequently and whose capacity was generally taken up with other priorities, it is clear that health care professionals, particularly nurses, did not perceive that they had any responsibility for or involvement in sorting out the issues of IPCC regulation, supervision and training. This section uses researcher reflections on study data to illustrate and explore this point.

The previous two findings chapters have illustrated how the IPCCs worked autonomously. Their interprofessional colleagues rarely delegated work to them directly and never supervised their contact with patients. While the work that IPCCs took on could be described as nursing work, no interview or focus group data reflect that nurses felt any responsibility for making sure that, as the IPCC role continued to shift into nursing territory, issues of training, regulation and supervision were appropriately dealt with.

It is clear from nursing contributions to focus groups that they did not feel they had a say in the development or focus of the IPCC role. This is clearly illustrated by

exchanges between nursing ward managers in a focus group on the IPCC role. While the ward managers did not complain about their lack of control over the role or raise it as an issue, the quotes below (all from different ward managers) illustrate that the decision-making about the role was perceived to lie elsewhere.

> I mean I'm glad they're moving [the number of IPCCs] up to four, I felt that for a long time that three, considering annual leave, considering sickness, it's perhaps it's not helped - I think it's long overdue that we've got four there. (Ward manager, 13049C, FG)

> It's where [the IPCCs'] authority is, if you are asking them to gather information and offer advice to us then that is okay, but if their brief is to gather information and then act without consultation with nurses, I think that is something different. I am not sure whether that is their remit though. Whether they have delegated authority or whether they just have their own authority. (Ward manager, 13049C, FG)

> How do [the IPCCs know which patients] need to see them and who doesn't, cos maybe we had somebody admitted who has got a dense [stroke], came in with an infection, but he's got 24 hour care at home, he doesn't need to see them, everything is already set up and it is our nursing assessment that will define whether they need to see those patients or not, so really it should be us that should be referring to them, not them getting it off PAS reading up every name that - surely that is making work - making more work for themselves anyway cos then they have got to go and look at every individual patient to see if they need to be seen. (Ward manager, 13049C, FG)

> The question I'd like to ask is somewhere along the way the hospital is now going to have to accept what [the IPCCs] are doing and give you the responsibility or they are going to have to accept that they are asking the nurse to take responsibility and therefore let us do it, and I don't mind which way they do it but I just don't want to be caught in between where I'm being asked to be responsible for something I'm not actually doing. (Ward manager, 15020F, FG)

The ward managers exhibited a perceived inability to change things even when the way the IPCCs worked clearly inconvenienced them:

> But then the other thing is as well is that it is more difficult because they're consultant-based and wandering all over the hospital, if they were ward based there are all the issues that are happening on the ward at that time, so if say, for instance, if a patient is due for discharge and the [take-home medications aren't ready], they would be on the ward, they would know that's not done, they are there to deal with it. Whereas if they are halfway around the hospital you're not going to bleep them up to deal with it. (Ward manager, 13049C, FG)

These perceptions that nurses had no influence on the IPCC role remained the same regardless of who was managing the IPCCs, that is, even when the IPCCs were being directly managed by the senior nurse. This perceived lack of influence echoes accounts of the top-down culture described earlier by managers. The IPCC role was working in an area of overlap with nurses, but these nurses, and this included the ward managers, did not perceive that they had an influence over how the IPCCs worked or a responsibility for the quality of their input to patients.

As illustrated in the previous findings chapters, the priority for nurses was the carrying out of acute physical care, with technical medical care being seen as the most important. Staffing shortages meant that nurses focused on this priority and perhaps this was a key reason they were not able to take up any responsibility they may have had in relation to ensuring that IPCC practice was safe. However, their level of busyness does not detract from the indication that practitioners shared with managers a view that their 'bottom-up' influence was constrained.

In summary, nurses did not perceive that they had an influence in development matters regarding the IPCC role. This will have meant that managers were not getting practitioner input about the IPCC role and its attendant issues, and this may also have reduced managers' imperative to act.

7.5   Chapter summary

This chapter addressed the fourth objective of this study and has examined the key contextual influences on the IPCC role. In spite of agreement about what changes needed to be made through the action research study, no changes resulted to the role or its management. A turbulent environment meant that managers and practitioners were too caught up with daily pressures to reflect and act on the issues raised. Managers' priorities were externally imposed and often related to government targets, including a prime target of achieving acute efficiency. Practitioners and managers exhibited perceptions of a 'top-down' organisational culture. The high level of managerial turnover also meant that there was a lack of a long-term overview of the progression of the role and the emergence of issues. Overall, the fact that the IPCC role was now seen as established and useful meant there was no priority given to its ongoing review.

The next chapter discusses the findings from these three chapters in their wider theoretical and empirical context.

8 Discussion

The aim of this study was to explore the issues arising from the development of a new flexible role in an acute medical in-patient setting. The study's objectives were to describe the characteristics of the IPCC role, to explore the impact of the role on interprofessional working and patient care, to highlight the issues arising from the operationalisation of the role and to identify the key contextual influences that shape the development of the role. In this chapter, the study's findings in relation to these objectives are discussed further and their theoretical and empirical significance explored. The findings are discussed with reference back to the socio-political context introduced in the second chapter to this thesis.

This thesis provides a case study of the NHS today. Through an exploration of a role in practice that is a direct reflection of contemporary government policy, these findings highlight the implications arising from the operationalisation of the managerial agenda relating to new roles in the NHS workforce. The findings also highlight key contextual issues of direct relevance to the management of innovations in the NHS. The chapter highlights in particular how the findings serve to both reinforce and build on contemporary theory in sociology and organisational development.

The literature review (Chapter 3) highlighted that very little is known about flexible roles in health care. A small number of studies identify issues of role confusion and boundary overlap at the point of introduction of care co-ordinator roles, but no studies had taken place on how these issues develop over time. Only one pilot study looked at care co-ordinators without a nationally registered qualification in health care and, in this small-scale study, data collection was focused on the role's introduction (Reeves et al. 1999a). The review identifies no studies that report on how roles such as these and the issues that arise from them develop over time, and very little about the contextual influences on the development of such roles. No work was identified that reports on how the feature

of flexibility impacts on roles such as the care co-ordinator role. As this chapter will illustrate, this study serves to fill some of these important empirical gaps.

The chapter begins by revisiting the key features of the study design, and illustrates how this lends weight to the claims made and conclusions drawn. The remainder of the chapter comprises four main sections. The first section argues that the IPCCs have occupied the jurisdictional vacancy of discharge planning previously filled by nurses. The section illustrates that while the findings lend support to theories of interoccupational changes in jurisdiction over particular areas of work, they also challenge theory that states it is always routine work (rather than complex work) that is passed on from groups of higher status to groups of lower status.

The second section illustrates how the study findings support theories of a growing challenge to professional knowledge and practice, and highlights how this can lead to the routinisation and marginalisation of important aspects of health care. The third section argues that a turbulent health service context shaped the development of the innovation of the IPCC role and illustrates how this both supports and adds to theory that context can influence the journey of innovations. The fourth section contends that a short-term model of innovation constrained managerial attention to supporting the introduction of the IPCC role at the expense of the longer-term issues that developed. The findings that the IPCC role continued to shift challenge current theory that re-invention ceases beyond the innovation's establishment into mainstream practice.

8.1   Reflections on methodological approach

Many of the relative strengths and weaknesses in study design have been discussed in detail in Chapter 4. This section reviews the key strengths and weaknesses in the light of the findings that have emerged. The section will enable the reader to assess the weight that can be attributed to the claims made in the remainder of the chapter.

A number of strengths in the design of this study lend weight to the findings and to the conclusions drawn. Firstly, an action research approach enabled an in-depth view of how the IPCC role was operating in practice and what the issues were that emerged. Lincoln (2001) notes how participatory forms of inquiry are distinguishable by the particularly egalitarian relationships between the researcher

and the researched, and by the level, intensity and duration of the commitment to a community by a researcher. The intensity of the relationship I formed with participants over a lengthy period of time allowed me access to data that would have been unavailable through formal data collection techniques alone. An on-site presence gave me access to multiple opportunities for informal observations and conversations that led to new reflections and lines of inquiry.

In addition, attempts to change practice during the study enabled an engagement with the issues that would otherwise have been more limited. For instance, Chapter 7 outlines the contextual influences on the development of the IPCC role. Many of these findings were drawn from the reflection phase of the study, a phase that encouraged participants to reflect on what had changed and what had not during the action research. In the absence of attempts to change, these reflections would not have been possible and little would have emerged about the contextual influences on the role.

Another methodological strength was the opportunity to study a new role two years after its introduction. This enabled changes over time to be identified and, as illustrated above, this meant important contributions to the body of knowledge. A weakness is that accounts of the role in practice at its outset were dependent on documentation, and the memories and accounts of participants two years on. It would have been useful to have also observed the role in practice at its introduction. Pragmatic reasons meant this could not be so but this would be a fruitful area for future study.

A further methodological strength was the wide range of methods used for inquiry and action. This enabled the role to be examined from a number of different angles, and added to the richness of the account given of the study context.

The case study approach taken enabled one setting to be studied in detail and in context, and this, plus the action research approach, have enabled a rich account of practice to emerge. The changes that were achieved during this study reflect the importance and validity of the findings to participants in the study setting. If the findings did not have catalytic authenticity (Lincoln & Guba 2000a), the changes that were made would not have happened. This is a further illustration of the

strength of participatory approaches, that is, their utility to the practice of participants (Heron & Reason 1997; Reason & Torbert 2001; Selener 1997).

Generalisations from this study's findings are possible in two ways. Firstly, the rich contextual description contained in this thesis enables the reader to judge the 'fittingness' (Lincoln & Guba 2000b) between the study context and their own experiences of health care, and draw conclusions as to the relevance of this account to their own practice. Secondly, the theories constructed and tested through the processes of data collection and analysis are more widely applicable beyond this particular setting and can be used to enhance understanding about current practice in today's health service. The claims made in the remainder of this chapter are particularly representative of this second form of generalisation.

8.2 Nurses retain routine work while discarding complex work

This section discusses the role shift undertaken by the IPCCs within the context of theory that highlights the constructed and continually shifting nature of boundaries between different occupational groups. Findings mainly drawn on are those that throw light on the first objective of the study, that is to describe the characteristics of the IPCC role.

The findings in the previous chapters illustrate that, over time, the IPCCs took on aspects of nursing work. These shifts in who does what in health care are reflected in other empirical studies and in contemporary theory. This theory states that the actual work performed by different occupational groups changes over time in response to a range of factors including ongoing attempts to establish and maintain jurisdiction over high status work, the introduction of new technology, labour supply factors, the development (or demise) of related occupations, organisational factors and government policy (Abbott 1988). Abbott describes how occupations[38] are bound to a set of tasks by ties of jurisdiction. However, none of these ties are permanent or absolute, and the processes of work can result in a reconfiguration of who does what. The findings of this study reflect these normal processes.

Occupational groups succeed in establishing a monopoly over higher status work and achieving status as a profession (Larson 1977; Macdonald 1995) by leaving

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[38] Abbott (1988) uses the term 'professions' throughout his work, but the more inclusive term of occupations has been used here in preference.

behind lower status or 'dirty' work for other groups to perform (Allen 2001; Hughes 1971). This in turn presents opportunities for other groups to achieve professional status by occupying the vacancy left behind (Abbott 1988). The research literature contains many examples of these shifts in jurisdiction between nursing and other groups (for example, Jones 2003; Read & Graves 1994; Roe, Walsh & Huntington 2001). A shift often focused on is the uptake of medical work by nursing, and this is often theorised as evidence of the quest by nursing to take on higher status work (Allen & Hughes 2002; Salvage & Smith 2000). What is less well researched is the work that nursing discards and more recent empirical work to explore the boundary between the work that registered nurses and health care assistants attempts to address this gap (Allen 2001; Spilsbury 2004; Thornley 1998; Thornley 2004). What, however, was unknown prior to this study was what happens when a group outside of the jurisdictional control of nurses altogether takes on work from nurses, particularly a group that does not have an equivalent training. These findings help to fill this empirical gap but also indicate that it may not always be the most routine work that is discarded to lower status occupations.

The IPCCs took on discharge planning work from nurses. Nursing shortages meant that other nursing work was prioritised. Abbott (1988) notes how increases in the demands made for a particular type of work or decreases in the capacity of an occupation lead to the 'degradation' of aspects of that occupation's work. Professional work can be divided into routine and non-routine elements, with routine work (that is, work of lower status) falling to the lower segments of a professional group (for example, juniors or trainees) or outside of the professional group altogether to 'paraprofessionals' (Abbott 1988, p. 125). The passing on of discharge planning suggests a priority order to aspects of nursing work, in which the work of discharge planning is seen as 'dirty' or routine enough to be managed by a group without qualifications (Abbott 1988; Hughes 1971). However, the IPCCs took on the discharge planning of the most complex patients while nurses retained the most routine patient discharges.

This finding challenges contemporary theory that it is always the most routine work that is passed on to lower status groups. Abbott's (1988) theory does not explain why it is that nurses discarded the more complex discharges (presumably

higher status) while holding on to the more routine discharges (presumably lower status). These findings suggest that there may be other factors at play.

While Abbott's (1988) theory includes an acknowledgement of the impact of external forces on jurisdictional ties, and uses illustrations that include the influence of central government and trends such as bureaucracy, the theory in this area is weaker. For instance, Abbott illustrates how the organisational context can influence jurisdictional ties but an opportunity is missed to explore what shapes the organisational imperatives that can dictate who does what. The second chapter of this thesis illustrated how increasing intervention by central government is influencing how health services are shaped and delivered. If, as the theory on new managerialism indicates, central government control is strong, its influence on the goals of individual organisations would seem important to acknowledge in a theory that already acknowledges the strong influence that organisational goals and other external forces can have on the interprofessional system.

Abbott's (1988) theory, however, is largely devoid of an appreciation of a wider socio-political context. In this study, it may be that it was a managerial agenda that informed nursing opinion as to what work to discard or retain, or, given the passive role taken on by nurses indicated in the findings, that dictated to nurses and IPCCs who was to do what. This study's findings illustrate the importance of the Trust meeting the goal of acute efficiency that was an early driver of New Labour health policy. The IPCCs' success in helping to meet this organisational goal, particularly when they took the lead in discharge planning for the most complex patients, could have influenced decision-making about who could best achieve this goal. Or it may be that, in an organisation focused on acute efficiency (that is, a concentration on providing only the physical care an individual needs while acutely ill), technical, medical work is valued above all else. These values influenced nursing views as to what high status work is. The findings illustrate that the physical care of patients was top of the nursing agenda and perhaps nurses did not reflect on who was doing what in discharge planning, as long as the work was getting done. If either or both of these scenarios is the case, it is evidence of the central government agenda influencing local decisions about who does what. Contextual issues are returned to later in the chapter.

These findings lend support to the theories of a continuous dynamic to occupational jurisdiction that enables lower status occupations to take up the discarded work of higher status occupations. They also, however, make a new contribution to the body of knowledge by challenging contemporary theory that it is always the routine work that is discarded and the non-routine work retained by higher status groups. The findings suggest that factors other than the desire for occupational advancement may influence jurisdictional ties. The next section discusses the findings relating to the impact of and issues arising from this jurisdictional change.

8.3   Routinisation and marginalisation

This section discusses study findings on the impact of and issues arising from the IPCC role in the context of theory that highlights a growing challenge to the primacy of professional knowledge and the authority of the professions to regulate themselves. In this setting, this challenge has taken the form of routinisation of aspects of care. This has led to a marginalisation of what was previously core nursing work.

The literature on new managerialism (see page 20 onwards) reflects a more active role since the 1980s by the state in challenging professional activities. This role includes broadening expectations of who can undertake previously solely professional work and encouraging the blurring of previous distinctions between occupational groups (Denis et al. 1999; Fournier 2000; Malin 2000). This approach is echoed in New Labour government policy that argues that the modern world is too complex for occupational distinctions to serve a useful function and that flexibility, team work and blurring of boundaries are required in order for professionals to respond effectively to this complexity (Cole & Perides 1995; Department of Health 2000; Fournier 2000). This line of argument reconstructs what was previously seen as professional work into routine work (Sheppard 1995) and presents an additional challenge to the notion of distinct bodies of knowledge known and used solely by members of individual professions.

Societal trends that legitimate consumer (or, as has often been the case to date, central government) involvement in previously solely professional matters include challenges to notions of absolute truth in science, an increasing legitimacy

attributed to consumers of professional services and their own knowledge, and considerably improved access to professional knowledge bases (through, for example, the internet and generally improved education levels) by individuals and groups who are not members of the professions (Busby, Williams, & Rogers 1997; Elston 1997; Giddens 1990; Scarbrough 1996). Scarbrough (1996) also identifies a huge explosion of specialised knowledge in all walks of life.

In addition, in relation to regulation, cultural trends which reflect a growing mistrust in professional self-regulation in health care have been brought to the fore by a series of very public scandals (for example, Bristol[39], Shipman[40], Allitt[41], Beech House[42]) and the growing recognition of gaps in the current regulatory structures (Allsop & Saks 2002). This has led to government policy to overhaul the concept of professional self-regulation, and by widening the scope of current regulation and by modernising structures (including increasing lay involvement), the current government aims to achieve greater accountability, consistency and transparency in order that patient protection and safety are enhanced (Allsop & Saks 2002; Baggott 2002; Department of Health 2001a). These moves represent growing state and public involvement in matters traditionally seen as purely professional territory (Allsop & Saks 2002).

As reflected in the literature review, other empirical studies on new roles suggest that additional training is needed for individuals taking up a new role (for example, Appleton et al., 1997; Jamison et al., 1999; Rolfe et al., 1999). However, they provide scant evidence for the educational needs of non-registered workers taking up the work of registered workers. In addition, studies on generic support workers and community mental health support workers reveal anticipated concerns about accountability to a number of different professional groups, but no follow-up studies have been done to see if these issues emerge in practice (Rolfe et al.1999; Shield 2002; Murray et al.1997). Studies on registered practitioners in new roles

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[39] From 1984-95 Bristol Royal Infirmary surgeons continued to carry out essentially experimental surgery on children in spite of a high rate of deaths. Trust managers and others did not take action to prevent such practices continuing (Kennedy 2001).
[40] Harold Shipman was a GP who, over the course of 24 years (up until 1998), murdered up to 300 patients (The Shipman Inquiry 2003).
[41] Beverley Allitt was a nursing assistant at Grantham Hospital with Munchausens Syndrome by Proxy who killed 4 children and injured 9 others between 1991 and 1993 (Clothier 1994).
[42] Beech House was a long-term care facility for older people in London in which patients were abused by nursing staff between 1993 and 1996 (Camden and Islington NHS Trust 2003).

that transcended traditional boundaries also illustrate complex issues of accountability and regulation (Read et al. 1999; Roe, Walsh, & Huntington 2001) but, prior to this study, little was known about the accountability and regulation of non-registered workers taking on roles that transcend traditional boundaries.

The following discussion illustrates how this study's findings help to fill these empirical gaps and lend support to contemporary theory that aspects of professional work are being routinised and that this can lead to the marginalisation of aspects of this work.

8.3.1 Informality reflects routinisation

The findings illustrate the relative informality of the IPCC role shift and the accompanying lack of attention paid to matters of training, regulation and supervision. This approach is in spite of findings that IPCCs are in fact undertaking complex work (as illustrated in the previous section). This informality provides evidence to support theories that aspects of professional work are being routinised. The findings suggest that this occurred in order that wider, often political, goals could be met.

The IPCC role continued to be described 'officially' as an administrative support role comprised of purely routine clerical work. The IPCC job description reflects a routine administrative role and the Trust discharge policy names nursing as the lead group for discharge planning. In addition, IPCCs and managers did not perceive that they needed training for the role, their maturity and common sense being most highly valued. The IPCCs' manager implied that only clinical work involving treatment and diagnosis of patients' physical problems required training. In contrast, the findings show that the IPCCs had high levels of skill and knowledge in many aspects of their work. The findings also highlighted that the IPCCs did not have a clear line of professional accountability that was evident in either policy or practice. IPCCs claimed that they were accountable to nurses on matters of discharge planning, but the observation data do not support these claims, illustrating a degree of autonomy in IPCC work that exceeded nursing support worker status.

These findings are evidence towards the theory of a challenge to the primacy of professional knowledge and work. It seems that IPCCs have developed a craft

version of professional work, which has enabled them to do the job without training. This matches the wider picture of reclassification by the state of some professional work into routine work in order that political goals are met (Fournier 2000; Malin 2000). The findings reinforce the socially constructed nature of professional knowledge.

The uptake of discharge planning work by IPCCs without the need for specialist training or managerial attention to matters of accountability or regulation was the most organisationally efficient means of achieving the substitution. By keeping the substitution informal, through the lack of change to Trust policy and IPCC job descriptions, the need to look more formally at managing the shift did not emerge. The IPCCs were clearly successful in helping the Trust achieve acute efficiency and it may have been this success that influenced the routinisation of this aspect of care. This is possible evidence of the influence of wider political goals on determining who does what, and the degree to which certain aspects of health care are viewed as routine. The influence of government targets on the management of the IPCC role is returned to below.

In addition to providing empirical support for contemporary theory, these findings add to what we know about the issues arising from the operationalisation of new roles. Training was provided to the IPCCs when they first started but, in spite of a significant role shift, no further training was provided. The role shift was also not reflected in managerial attention to the implications for IPCC accountability, regulation or supervision. This was in spite of the fact that the IPCCs were not covered by current legislation or professional regulation in the work they were doing. Because the IPCCs' work was 'officially' viewed as clerical support work to nursing staff, there was no perceived need to look more closely at these matters.

Existing professional regulation is currently largely based on protection of title rather than protection of particular spheres of practice, and on divisions between occupational groups (Price 2002). So, for example, it is illegal to identify oneself by any title protected by statute (for example, registered nurse or registered medical officer) but not illegal to treat a sick person in the absence of training, providing the patient has given informed consent (Price 2002). The way law is shaped in this area means that anyone can perform any act in health care, with a few notable

exceptions (these exceptions include prescribing, dentistry and attending women in childbirth, other than in an emergency).

This reliance on protection of title means that groups such as support workers and generic workers have not to date been covered by legislation, in spite of their increasing use in health and social care. This is now being addressed to some extent through new proposals to introduce regulation for support workers under the Health Professions Council (Department of Health 2004a), a move that also reflects the growing state involvement in occupational regulation (Allsop & Saks 2002; Baggott 2002; Department of Health 2001a). There is a focus in these new proposals on the regulation of staff with a direct impact on clinical care. This is defined as 'face-to-face provision of prevention, diagnosis, treatment and care sometimes involving the application of clinical judgement' (Department of Health 2004a, p. 8). This presumably involves discharge planning. However, as these findings highlight, even this newly proposed legislation would not fully protect against managerial decisions to inappropriately designate certain areas of work as clerical. In addition, until these proposals are translated into legislation and practice, there continues to be a reliance on a uniprofessional model of professional regulation. This means that particular areas of practice, such as discharge planning, are not regulated and therefore, under law, can be practised by anyone.

These findings emphasise the importance of the study of new roles over longer periods of time. In this study, new requirements for training, regulation and supervision had developed over time but there was no formal acknowledgement that these skills and knowledge actually existed. These findings match the findings of other studies on new roles that transcend traditional boundaries but also add new information. This study shows an even greater degree of uncertainty in practice in the absence of an original professional affiliation and the absence of a clear line of accountability to one professional group.

The implications of the routinisation of aspects of nursing work are examined in the next section.

8.3.2   *Important aspects of care marginalised*
These findings support theory that states that work that is not viewed as core work to a profession is at risk of being marginalised in situations where aspects of

professional work are being routinised (Sheppard 1995). In his studies on social work, Sheppard (1995) found that the routinisation of some professional tasks had led to the marginalisation of less tangible elements of professional work such as interpersonal skills and reflexive responses to situations. The findings on the IPCC role indicate similar processes in health care and highlight the impact of such a marginalisation.

Findings showed that IPCCs were, on occasion at least, practising in areas for which they did not have the requisite skills and knowledge. The occasions identified usually involved a lack of skills and knowledge for the psychosocial aspects of direct patient and family involvement. This lack of skills and knowledge, in the context of the managers' views that additional training was not required, suggest a marginalisation of the knowledge and skills needed for psychosocial care.

In addition, the lack of managerial attention to matters of regulation, supervision and accountability reflects a marginalisation of the importance of the work that the IPCCs were doing. Unless practitioners like the IPCCs are members of existing professional groups or the members of an existing professional group take on the accountability and responsibility for the work of these practitioners, patients have a lesser degree of protection and redress than under traditional professional regulatory structures. While these study findings indicate a potential, rather than actual, negative impact on the quality of patient care, they usefully highlight areas of concern that could emerge in situations such as, for example, negligent or unwitting misconduct by individual practitioners.

These findings on the issues arising from the IPCC role and the impact of the role have highlighted the constructed nature of professional knowledge and lend weight to theories of growing challenges to the primacy of some aspects of professional knowledge and practice (Eraut 1994; Fournier 2000). Because IPCC work was perceived as merely clerical work and the shift into professional territory had remained unacknowledged in job descriptions and Trust policy, then training, regulation and supervision implications were deemed to be minimal. However, if it had been perceived as professional work, training, regulation and supervision would have been of a different order. The findings have also highlighted how such routinisation can lead to the marginalisation of some aspects of health care.

8.3.3   *Tensions between flexibility and role clarity*

These findings add an interesting perspective to what we know about the new managerialist stance that has shaped the development of health service roles and services. While recent government policy trumpets the patient-centredness of the service modernisation it seeks to achieve (Department of Health 2000; Department of Health 2004c), these findings suggest that important aspects of patient care may be being marginalised. Needs for training, regulation and supervision may not be as clear-cut as current policy implies. In the second chapter of this thesis, it was illustrated how current policy equates patient-centred care with fast and efficient care. The IPCC role was valued for its patient-centred approach. However, if as these findings illustrate, the role's practice and management marginalised important but less tangible elements of patient need, perhaps a patient-centred approach cannot be claimed.

These findings highlight a fundamental tension between the need for flexibility and the need for role clarity. On the one hand, occupational flexibility is championed by the state and on the other hand regulation is tightening. These findings illustrate the desirability of flexibility in occupational roles: the flexibility of the IPCC role was seen to promote patient-centred care, enabled the role to adapt in line with local needs, particularly workforce difficulties, and enabled gaps in care to be filled that would not otherwise have been filled. In addition, other advantages to the role included a valuable contribution to team working (through time-saving and being a source of information for colleagues) and a possible role in enhancing communication between team members.

However, absolute flexibility and role clarity are incompatible, and much of current regulatory arrangements rely on role clarity. These findings illustrate that it is not possible to fully specify competencies when a role has flexible boundaries, and that in areas where supervision is needed and where patient protection needs considering, the lack of accountability to an existing professional group and gaps in current regulation can be problematic. In addition, the flexibility of the role may have exacerbated difficulties new staff had in understanding the role.

The study findings on the issues and impact of the role lend empirical weight to existing theory on challenges to professional knowledge and practice through the routinisation of aspects of core practice. They also provide evidence that, in health

care, marginalisation of aspects of care may result. These findings underline the socially constructed nature of professional knowledge. The findings also illustrate a fundamental incompatibility between role clarity and role flexibility.

8.4　A turbulent health service context shaped development of innovation

This section draws on findings related to the fourth objective of the study, that is to explore the contextual influences on the IPCC role. This objective responds to literature review findings that little is known about the contextual factors that shape the development of new practitioner roles in health care. The section focuses on the IPCC role's progress in its journey as an innovation. By the time this study had commenced, the role had been in existence for two years and had become part of mainstream practice in the directorate. However, as has been illustrated, given its flexible boundaries, the role had continued to change. In addition, the role continued to be new to patients and new staff in the directorate who had not come across an IPCC before. For these reasons, it is still appropriate to think about the role as an innovation for the purposes of this analysis. Theory on the diffusion of innovations will be used here to frame the discussion.

In spite of what may be a desire by policy makers, managers and practitioners to approach innovation in a rational, planned way, it is, in fact, generally not a predictable or linear journey and is subject to the influence of a variety of factors (Greenhalgh et al. 2004; Van de Ven et al. 1999; Wolfe 1994). More recently, health service researchers have begun to highlight the impact that the context of the NHS can have on the journey of innovations.

Theory on the diffusion of innovations in different contexts is not well developed (Wolfe 1994), and the particular professionalised context of the NHS has not been well researched to date (Dopson et al. 2001; Fitzgerald et al. 2002; Greenhalgh et al. 2004). Understanding is growing of how context plays a key part in determining the innovation journey and that the UK NHS context has distinctive features that merit recognition. For instance, one distinctive feature is the part that health care practitioners play in the innovation process. Research to date suggests that they play an active part in the interpretation, reconstruction and negotiation of new scientific knowledge for local use (Fitzgerald et al. 2002; Wood, Ferlie & Fitzgerald, 1998; Dopson et al. 2002; Ferlie, Fitzgerald & Wood 2000). Fitzgerald

et al. (2002) argue that the active nature of the engagement of health care practitioners with potential innovations represents an activity that goes beyond conventional understandings of re-invention of the innovation. Altering and customising the innovation included practitioners framing their own agenda, selection and prioritisation, innovation-seeking behaviour and constant renegotiation (Fitzgerald et al. 2002). This level of engagement indicates that the presence and participation of health care practitioners can have a significant influence on the journey of an innovation, and must therefore be considered as part of the context. Research in this field builds on understandings about managing change in professionalised organisations but concentrates on the part played by registered workers.

In addition to the presence and part played by health care practitioners, other features of the NHS context also have an influence on the innovation journey. A number of context-specific variants ranging from government policy through to influences specific to an individual practitioner have been suggested by research to date, but the complexity of the mix and contribution of different variants makes more work in this area of great importance (Dopson et al. 2002; Greenhalgh et al. 2004; Locock et al. 2001).

Complexities highlighted by recent NHS change management literature also add to our understanding of the NHS context. Factors such as changing environmental pressures, multiple stakeholders with a range of prior experiences of change, the complexity of NHS organisations particularly the professionalised context of much of the work and the potential for unintended, sometimes dysfunctional, consequences all mean that change in the NHS is unlikely to be straightforward or linear (Ferlie et al. 1997; Iles & Sutherland 2001; Powell, Brock, & Hinings 1999).

One of the key gaps identified in the literature review for this thesis is that little is known about contextual factors that shape the development of new practitioner roles in health care. As will be illustrated, this study's findings help to fill this empirical gap.

This study's findings add to our understanding of the NHS context on the journey of innovations, particularly new roles, and lend empirical weight to theoretical claims that context can influence the journey of an innovation. Findings in the

previous chapter in particular have highlighted a number of organisational features that influenced managers' ability to reflect on the role beyond its initial introduction and act in response to the identified need to set up suitable systems for IPCC training, supervision and regulation.

Managers described a turbulent context to their work and it was this context that constrained their ability to act reflectively in relation to the IPCC role. The context of their work was characterised by multiple pressures requiring a speedy, reactive response and a top-down agenda influenced by government targets. Managers in particular valued the IPCC role for its contribution to achieving acute efficiency, and it was this goal that was commonly cited as driving the managerial agenda. In addition, managerial turnover was high and this contributed to the turbulence that constrained reflective management.

In her action research study on lay participation in care in an NHS hospital setting, Meyer (2001b) identified a number of environmental features that contributed to difficulty in changing practice. These included participants' perceptions of a significant amount of change and uncertainty that was imposed by government and left participants feeling low in morale and unable to control their own destinies. Examples of such changes cited by Meyer include the introduction of general management and the changes in nurse education associated with Project 2000. Meyer's study was conducted in a different UK hospital in 1988-89 and it is interesting that these findings reflect a similar culture.

Pettigrew, Ferlie and McKee (1992) have identified a number of factors that contribute towards a receptive context for change. One of these factors is coherence or consistency between goals (Pettigrew, Ferlie, & McKee 1992; Pettigrew & Whipp 1991). Pettigrew, Ferlie and McKee (1992) identify that coherence includes a marrying of top-down pressure and bottom-up concern, and this contributes to a receptive context for change. In the apparent absence of a channel for their bottom-up concern, it is perhaps unsurprising that managers felt unable to engage in more strategic issues about the IPCC role.

The existence of a top-down agenda that drives priorities echoes theory on the new managerialism that identifies the 'command and control' influence that New Labour in particular has achieved. The aim of New Labour to achieve greater

accountability in public services has led to performance management emerging as a key managerial duty (Ferlie & Fitzgerald 2002). This has been underlined by reporting mechanisms on a variety of measures (including length of stay and waiting times for treatment) alongside inspections by the Healthcare Commission[43] on a range of measures including compliance with National Service Frameworks[44] and National Institute for Clinical Excellence[45] guidelines. Commentators claim that this focus on performance measurement coupled with the threat of central intervention if performance is poor have replaced competition as the central incentive for health service managers (Klein 2001; Lapsley 2001). These findings, particularly those that relate to the drive for acute efficiency, lend support to this theory and indicate that central government was successful (in this directorate at least) in influencing the agenda for action by managers.

These findings also highlight how a high turnover of managerial staff can constrain the development of a long-term and reflective view that promotes more proactive managerial action. Meyer's action research study (*ibid*) also identified how the transience of staff constrained positive practice developments, but in her study it was clinical staff rather than managerial staff who were most commonly identified (Meyer 2001b). These findings of a 'fuzzy set' of stakeholders around an innovation whose input comes and goes are also reflected in the innovation literature (Van de Ven et al. 1999). This states that many people are involved in the diffusion of innovations, but most only partially, as their attention is often distracted by other roles unrelated to the innovation (Van de Ven et al. 1999). Stakeholders in the innovation come and go over time, and there is often no one stable team of individuals overseeing the innovation journey.

Given that the innovation of the IPCC role (because of its flexible nature) had its journey over an extended period of time, the likelihood of multiple stakeholders had increased, as had the subsequent difficulties of one person having a longer-term overview. Importantly, in line with the theory, the innovation itself continued to develop and flourish in spite of the fuzzy set. However, the turnover of

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[43] The Healthcare Commission is a statutory inspection body which audits every Trust.
[44] National Service Frameworks are national standards that are symptom-specific (e.g. coronary heart disease, mental health) or set for particular patient groups (e.g. older people, children).
[45] National Institute for Clinical Excellence (NICE) carries out evidence-based appraisals (including appraisal of cost-effectiveness) of clinical interventions and issues subsequent recommendations. NICE also authorises evidence-based clinical guidelines (Harrison 2002).

managers meant that there was no ongoing review of the role and its implications in the face of continuing shifts in focus.

The organisational change literature highlights the importance of managerial stability in the effective management of strategic change (McNulty & Ferlie 2002; Pettigrew, Ferlie, & McKee 1992). Pettigrew et al. (1992) point out that the unplanned movement of key personnel results in draining of energy, purpose, commitment and action from a change programme, and that the change programme 'goes into a period of regression leaving the newcomer manager to start again but now possibly in a soured and non-receptive context for change' (p.278). These findings lend support to this theory that there is a loss of momentum in a change programme in the face of managerial turnover.

The findings also throw light on the role played by practitioners in the journey of this innovation. The findings that the decision-making about the IPCC role was perceived by nurses to be out of their control is echoed in Allen's (2001) study. Allen found that ward nurses failed to identify nurses in management as responsible for implementing unpopular initiatives. Instead, nurses in Allen's study referred to 'management', 'the hierarchy' and the 'higher ups' and portrayed 'management' as remote and out of touch with the reality of ward life (p. 100). In contrast, nursing managers in Allen's study were at pains to distinguish themselves from medical and general managers, and saw themselves first and foremost as nurses. In relation to the IPCC initiative, nurses in this study exhibited a sense that managerial decision-making was top-down and remote from nursing concerns, and this also has echoes of the central 'command and control' culture promoted by central government. The passivity exhibited by the nurses above in relation to shaping the IPCC role suggests that they felt removed from decision-making, rather than the fact that they had no issues with the role.

As illustrated earlier, the priority for nurses was the carrying out of acute physical care, with technical medical care being seen as the most important. Staffing shortages meant that nurses focused on this priority and perhaps this was the key reason they were not able to take up any responsibility they may have had in relation to ensuring that IPCC practice was safe. It may be that given multiple competing demands, nurses used an acute medical model as the most straightforward way to define the priorities in their workload.

While previous research has indicated that health care practitioners play an active part in customising innovations for their local utility (Dopson et al. 2002; Ferlie, Fitzgerald, & Wood 2000), these findings suggest a passive role can instead be taken. Nurses in this study deferred responsibility for how the IPCC role was shaped to more senior managers and to the IPCCs themselves. This difference may be because much of the previous research has looked at the part played by medical staff, a traditionally dominant group, or on multidisciplinary teams, while this study has examined the part played by nurses, a group that has traditionally been more influenced by state and/or organisational needs (Allen 2001; Davies 1995; Johnson 1977; Macdonald 1995). Or it may be a difference in the nature of the innovation. Previous research has focused largely on the introduction of new scientific evidence into clinical practice, while this study looks at the issues arising from a shifting role.

Overall, these findings of a turbulent environment in which other priorities take precedence for managers lend support to the theory that organisational context plays a part in shaping the journey of innovations. The findings also suggest that a professionalised health care context does not necessarily mean the active engagement of registered practitioners in negotiating role shifts or providing leadership around them. This may just occur after the innovation has become established into routine practice or it may be that an overriding model of acute efficiency primarily shapes practitioner responses.

8.5   A short-term model of innovation

This section also draws on theory on the diffusion of innovations. As mentioned above, the journey of innovations through to their establishment into mainstream practice is not a predictable or linear journey (Greenhalgh et al. 2004; Van de Ven et al. 1999; Wolfe 1994). Instead of a stage-wise sequence representing a journey from initial creation through to establishment of the innovation into mainstream practice, the organisation moves 'back and forth between initiation, development, and implementation, punctuated variously by shocks, setbacks and surprises' (Greenhalgh et al. 2004, p. 16).

During implementation, the innovation is often re-invented from its original form to enable it to be customised for local situations or changing conditions

(Greenhalgh et al. 2004; Rogers 1995; Van de Ven et al. 1999). Given the complexity of the innovation journey, the consequences of an innovation can be unanticipated and/or undesirable, and these outcomes can occur over extended periods of time (Rogers 1995). The innovation (and, current theory implies, any associated re-invention) terminates once it is implemented and institutionalised (Rogers 1995; Van de Ven et al. 1999). The practice or technology still exists but it is no longer regarded as an innovation.

This study's findings challenge the notion of an end-point to the journey of an innovation. As will be illustrated, this view of innovations is reflected in current health service guidelines on the development of new roles and, as these findings show, in a short-term approach to managing new roles.

Current guidelines on good practice in introducing new roles acknowledge the reflection and action required when a new role in health care is introduced, particularly when it represents a challenge to traditional ways of working (Levenson & Vaughan 1999; NHS Modernisation Agency 2003c). These guidelines, particularly the evidence-based guidelines (Levenson & Vaughan 1999), provide detailed advice on a wide range of areas including training, supervision and regulation. For example, the NHS Modernisation Agency (2003c) states that 'those managing staff in the wider healthcare team [should] have a clear understanding of the skills, competencies, and responsibilities of such staff, so that delegated tasks are adequately monitored and supervised' (p.6). Current policy guidelines, however, stop short of acknowledging that, as roles change over time, so may requirements for training, regulation and supervision.

These findings indicate that managers and practitioners were operating with a linear model of innovation, and that they worked on an assumption that managerial and professional attention were required as an innovation is introduced and established, but not once the role was part of mainstream practice and working effectively in helping to achieve acute efficiency. This contrasts with what we know about the diffusion of innovation, which suggests that the process is far from linear. However, current theory also implies that, once the innovation is established, re-invention no longer occurs (Van de Ven et al. 1999; Rogers 1995). While other work in this field suggests that health care professionals play an active part in customising innovations to their own local utility that represents a deeper

level of engagement than standard re-invention (Fitzgerald et al. 2002), there is an implication that once the innovation is implemented and becomes part of established practice, that is the end of the story.

In contrast, these findings suggest that re-invention can actually continue to occur if an innovation is granted an inherent flexibility. As has been illustrated, flexibility enables new work to be taken on in line with the demands of organisational targets and individual patient needs. Given that these factors do not remain constant, it is unsurprising therefore that re-invention continues to be needed.

It is also possible that the particular context of the NHS and the nature of the innovation as a new role rather than, say, a new piece of machinery, impacted on the journey taken by this innovation and increased the likelihood of it having a complex journey. We know that NHS settings are complex and influenced by a wide range of factors from individual behaviour through to government policy (Dopson et al. 2002; Greenhalgh et al. 2004; Locock et al. 2001), and the fact that the IPCC roles were each held by individuals with a range of personal characteristics added a further layer of complexity to the innovation journey. This complexity adds to the likelihood of a non-linear journey and accounts, at least in part, for the continuing re-invention of the innovation.

All in all, this situation meant that few checks were in place to monitor and respond to the role shift undertaken by the IPCCs and the implications this had. It seemed that managers had no time to stop and think, and practitioners were focused on acute physical work and did not see IPCC role development as their responsibility. However, even when the action research study undertook this monitoring and engaged with managers and practitioners to reflect and agree what needed to be done, no changes were made to the IPCC role or its management. Other priorities, often to do with national performance targets, worked against the existence of a reflective culture in which staff could feel in control of their daily priorities. The role and the involvement of IPCCs in nursing work was now established and accepted, and the time for reviewing this 'innovation' had passed.

These findings are reflected in the published guidance available about new roles in health care. Current guidelines offer little in the way of guidance over the long-

term. Levenson and Vaughan (1999) advise that job descriptions need regular review to ensure that they accurately reflect practice, and that new roles themselves also need to be kept under review to ensure that they remain useful and evolve in line with patient needs and clinical advances. They note that new roles may have a knock-on effect on other related roles and that, for example, where new posts attract heavy workloads, thought may need to be given to appointing support staff or additional post-holders. Levenson and Vaughan express a commitment to continuing professional development, but this seems to be in the context of staying up to date in their specialty, rather than acknowledging that role shifts over time may require training in whole new areas. In addition, this guidance is based on empirical work carried out on new roles held by registered nurses and professions allied to medicine (PAMs) (Read et al. 1999). The NHS Modernisation Agency (2003c) covers the possibility of staff without a registered qualification taking on new roles. It acknowledges that roles will evolve over time as needs dictate, but restricts its subsequent advice to thinking about replacing a post-holder who leaves and ensuring the new role remains relevant and sustainable. The advice, however, stops short of acknowledging that, as roles change over time, so may requirements for training, regulation and supervision.

This guidance reflects an approach to innovation that assumes that the end of the innovation journey is the establishment of the innovation into routine practice. This approach encourages managerial reflection and action prior to the innovation being introduced and during the process of its introduction, but does not reflect the longer-term implications of significant role shifts.

These findings raise questions about how long an innovation may need to be monitored. If roles are left deliberately flexible, then role shifts and the consequent cumulative effect of unintended consequences may well occur over long periods of time, incurring new requirements for training, supervision and regulation. However, if organisational energy is by this time focused on other things, these requirements may be ignored at the cost of patient safety and quality of care.

These findings add something new to theory on the diffusion of innovations. They indicate that innovations that retain flexibility beyond their acceptance into routine practice may continue to be re-invented in response to various influences. They also indicate that the complex context of the NHS and the 'human factor' inherent

in role innovations add to the likelihood of re-invention. This may require that new roles, particularly flexible roles, continue to be considered as innovations for an indefinite period of time because as the innovations shift and change, attendant processes such as training, regulation and the monitoring of unintended consequences may need to be reviewed.

Current management practice and guidance appear to echo current theory, concentrating managerial energy on introducing an innovation, and then moving on to other priorities once the innovation has been accepted into practice. These findings suggest that a longer-term view of flexible innovations is needed, as they may continue to shift and change over extended periods of time.

8.6   Chapter summary

A number of important findings have emerged from this study. These relate to the introduction and ongoing management of new roles in health care. Findings illustrate how the new role of IPCC shifted since its introduction from a purely clerical role to one that included aspects of work previously undertaken by registered professionals. A number of issues emerged from this change of roles within the interprofessional team, but important organisational factors constrained the ability of managers and practitioners to respond to the issues raised. This chapter concludes with a summary of the contributions this study makes to the body of knowledge. The findings have filled a number of empirical gaps, provided empirical support for existing theory and added to existing theory.

8.6.1   Empirical contributions

Findings illustrate how this care co-ordinator role was perceived to have a largely positive impact on patient care and interprofessional working. Findings also highlight how flexible roles such as the IPCC role can shift over time and can, in particular organisational circumstances, take on the work of other groups. This role shift can have the impact of altering the jurisdiction for particular areas of work, but as these findings illustrate, it is possible for this shift to remain informal and for the new issues that have emerged from the shift not to be addressed.

The findings illustrate that training needs can shift over time, but also that the need for additional training may go unacknowledged. The study also highlights a significant degree of uncertainty about where professional accountability lies for

roles in which the post-holders do not have an original professional affiliation and/or that are not designated with a clear line of accountability to an existing professional group. The findings underline the limitations of the uniprofessional nature of the current regulatory system and also highlight that accountability issues can shift over time.

Finally, the findings throw light on key contextual factors that influence the development of new roles and lead to the marginalisation of aspects of health care. A turbulent environment and a sense of a lack of control by both managers and practitioners influenced their ability to reflect and act on the issues raised through the action research. The managers and practitioners thus exhibited a short-term approach to innovation, in which energy was applied to the introduction of the innovation, but then their attention moved on to other priorities once the innovation had been accepted into practice.

8.6.2 *Theoretical contributions*

This section summarises where the findings add to, challenge or support existing theory.

The findings provide empirical support for Abbott's (1988) theory of an interdependent system of professions in which jurisdictional ties can be changed, and in which one group can take on the discarded work of another group in the face of organisational influences on demand and capacity. They also challenge Abbott's theory that it is always low status work that is discarded. This is a new contribution to the body of knowledge and highlights the importance of an appreciation of the wider socio-political context in which decisions are made about who does what. The findings also support theories of a growing societal challenge to the primacy of professional knowledge and an organisational culture in the health service in which broader expectations now exist about who is eligible to deliver health care services to patients and their families. These changes, as these findings confirm, can lead to the routinisation and marginalisation of some aspects of health care.

Finally, this study makes two important new contributions to the theory on the diffusion of innovations. Firstly, it illustrates how an innovation can continue to be re-invented beyond the point of its establishment into routine practice. Previous

theory had indicated that re-invention ceases once the innovation is established into routine practice (Rogers 1995; Van de Ven et al. 1999) and these findings challenge that assumption. It may be that the flexible and human nature of the innovation and the particularly complex nature of the health service enabled re-invention to continue in this case.

Secondly, the findings also support and add to theory that context has an important impact on the journey of innovations.   They highlight a turbulent context in which managerial turnover was high and managers' priorities were set by top-down targets and multiple pressures so that crisis management was the only available way to manage. This context constrained managers' abilities to monitor and manage innovations over the longer term. The findings indicate that a disruption to reflective leadership can play a significant part in the journey of innovations. The response of practitioners in this study to the IPCC role adds an alternative angle to the part that NHS registered workers play in the diffusion of innovations, and suggests that a passive role may be taken in some circumstances.

The final chapter to this thesis focuses on the recommendations arising from this work.

9 Closing comments and recommendations

The IPCC role emerged at a time when a new approach to public sector management has provided a fundamental challenge to traditional modes of professional working in health care. This challenge includes a broadened expectation of who could deliver direct patient care. As part of its modernisation and reform process for the NHS, New Labour advocates the development of patient-centred services and the dismantling of traditional demarcations between the professions. This includes the development of new roles and the redesign of current roles into roles that have the flexibility to deliver patient-centred care. This study of the IPCC role provides a cameo of the flexible working championed in this policy.

The study began eighteen months after the New Labour government first took office so many changes introduced by them had yet to take effect. However, a number of contextual features identified through the study almost certainly remain relevant today. Firstly, continuing workforce issues mean that the push for new ways of working (including role redesign) continues to be reiterated in recently published health service policy (Department of Health 2004c). In addition, the development of new roles has been taken up by many Trusts in England as a strategy to address shortfalls in staff numbers (Carr-Hill, Currie, & Dixon 2003).

Secondly, the need to retain an appropriate balance between acute and other services remains a primary concern, and this is again reflected in recent policy published in the Department of Health's new five year plan (Department of Health 2004c). And thirdly, while there have been a number of moves aimed at devolving power away from central government, these moves have largely taken place within a framework set by central government and with a continued emphasis on national standards and accountability (Robinson 2002). Therefore, for the moment at least, the 'command and control' tag still applies, albeit operationalised in a different way (Ferlie & McGivern 2003). These key examples provide evidence that the findings of this study still have relevance today.

As highlighted by the previous chapters, the findings from this study have made a number of important contributions to the body of knowledge. This chapter focuses on the recommendations for policy, practice, education and research that follow.

9.1.1 *More care needs taking with new roles*

The findings highlight a fundamental tension between the need for role clarity and role flexibility. While IPCC role flexibility enabled staff shortages to be covered, patient-centred care to be delivered in some instances and gaps in care to be filled that would otherwise have not been met, the lack of clarity about the scope and boundaries of the IPCC role meant that competencies could not be fully set for the role and that there was a mismatch with current regulatory systems.

The findings indicate that the IPCC role was not solely the product of local decision-making based on an analysis of local patient need, but subject to wider influences particularly government priorities for acute efficiency. In the light of these findings, reflection on the influence of political goals on service developments needs to form part of responsible health service leadership.

The lack of fit of the IPCC role with any role that had gone before, or with any existing occupational group, meant that making arrangements for educational provision and proper regulation was new territory to Trust managers. It is probable that more substantial national guidance, particularly that recognised role shifts over time, would have helped to prevent the emergence of issues that did occur. Given the plethora of new roles developing in health care, the moves now being made to make regulatory coverage more all-encompassing through the development of the Health Professions Council and the proposed regulation of support workers are welcome (Department of Health 2001a; Department of Health 2004a; Health Professions Council 2003). In addition, the knowledge and skills framework currently being developed as part of the Agenda for Change plans (see p.18) may help give clearer definition to what competencies are required for work in which substitution is being considered (Department of Health 2003d). These findings, however, underline the special considerations that flexible roles need, that is that competencies for such roles cannot be fully specified and that skills, knowledge and regulatory requirements for such roles may change over time.

Recommendation 1: The findings have highlighted how terms such as patient-centred care and flexibility are socially constructed and a clearer definition of terms in government policy would be helpful here. As has been illustrated, flexibility is not in itself an inherently good thing (although it is also not necessarily a bad thing), and a clearer specification of its limits in policy would aid improvements in the quality of care, and ensure that patients remain protected.

Recommendation 2: The number and scope of government targets for the health service is currently under review (Department of Health 2004b) and this is welcome. Care needs to be taken that national and local incentives to reach targets on quality of care in its widest sense are as great as those that promote the best use of resources.

Recommendation 3: The adoption of current government proposals out to consultation to extend regulatory systems to support workers in health and social care would fill the regulatory gap identified through these findings (Department of Health 2004a). The clarity and wide scope of these proposals are welcomed. However, these findings highlight how some areas of practice may be subject to local interpretation as clerical support work when, in fact, they can significantly impact on patient experiences and outcomes. It may be that the scope of the current proposals needs to be widened even further.

Recommendation 4: In the event of role substitution for one occupational group by another, careful review needs to be undertaken to ensure that important aspects of patient care are not marginalised. This review could usefully include direct observations of practice and seeking out patient views and experiences.

Recommendation 5: It is recommended that the specification of educational requirements for new roles are based on observations of practice that focus on the needs of the patient group and of the individual practitioner. The content of work and the associated competencies should be evaluated prior to its substitution to ensure that substitution does not result in less skills and knowledge being applied to the work. Serious consideration should also be given to the provision of clinical supervision and the development of reflective skills in new practitioners so that they are able to contribute to the identification of their needs for educational

support. Also helpful would be a commitment by the organisation and its staff to the concept of a lifelong approach to learning and development.

Recommendation 6: It is recommended that the introduction of new roles is accompanied by a systematic appraisal of accountability and regulatory arrangements. This should result in the identification of clear lines of accountability for practitioners and clear systems of redress for patients and their families. Where it is not possible to achieve full clarity, contingency arrangements should be agreed, clearly documented and communicated to the relevant parties.

Recommendation 7: It is recommended that further study takes place into flexible roles in practice, given their prominence in health service policy.

Recommendation 8: It is recommended that more work is conducted to enhance the understanding of the socio-political context on jurisdictional ties between different health care occupations.

9.1.2 *Longer term monitoring of innovations needed*

Findings reflect that current guidelines on the introduction of new roles are dominated by a linear model of the diffusion of innovations, in spite of theory that indicates the diffusion process is far from linear. Managers in this setting also used this model to determine their input. This meant that there were no checks and balances in place as the role shifted into new areas and that patients were potentially put at risk because of this. These findings also suggest that the feature of flexibility means that re-invention of a role will continue over the longer term, perhaps indefinitely. Re-invention certainly continued beyond the point at which the role could be said to be established in the service. These findings have important implications for policy, practice, education and research.

Recommendation 9: It is recommended that the job content of roles that transcend traditional boundaries, particularly those with a feature of flexibility, is reviewed every 6-12 months. This review should incorporate a variety of perspectives, including direct observation of practice, and input from practitioners, their colleagues and patients.

Recommendation 10: It is recommended that regular role review results in a reappraisal of practitioners' needs for training and clinical supervision, and that these needs are met as a priority in delivering a quality service.

Recommendation 11: It is recommended that regular role review prompts a re-evaluation of the practitioner's lines of accountability, means of regulation and systems for redress by patients and their families, and that any changes are made and communicated without delay.

Recommendation 12: Regular role review should result in the updating of relevant documentation including job descriptions and local policy.

Recommendation 13: The amount of managerial resource allocated should acknowledge the degree of managerial reflection and action needed for roles that may continue to shift over indefinite periods of time.

Recommendation 14: Further study should take place in the form of more longitudinal studies that follow flexible new roles from their introduction over the course of a longer period of time, say five years, to determine if shifts continue to occur, and how attendant issues develop over time. Study of this nature would enable further important contributions to the body of knowledge.

9.1.3 *The importance of context needs acknowledging*

These findings have highlighted the importance of context in influencing the journey of innovations. We have seen here that an environment that takes up managerial time and energy through the priority given to a range of externally driven priorities and targets can lead to the development of a reactive culture, in which the priority given to development work and appropriate monitoring of innovations can be very low.

The high turnover of managers here is also an issue. Where managers stayed in place for three years or more, it seemed they were able to take a longer-term look and respond to underlying issues in a more reflective way. These findings reflect the disruption and loss of momentum that events such as organisational restructuring can cause. Given the frequency of restructuring that has taken place in the NHS since its inception, but that has gathered pace over the past 15-20 years, these findings suggest that disruption to reflective leadership may be an important influence on the journey of innovations.

Recommendation 15: It is recommended that the day-to-day priorities of health service operational managers are re-appraised on a regular basis to ensure that

development and innovation work play a part in their daily activities and are not overshadowed by other multiple pressures.

Recommendation 16: It is recommended that consideration is given by government and Trust boards to how to retain individual managers and reflective leadership in the face of organisational restructuring. It is possible that the loss of managerial expertise and experience from an organisation could outweigh the gains made by, for example, changes in the management structure.

Recommendation 17: Further study is recommended to enhance understanding of how the particular context of the NHS influences the journey of innovations.

9.2   Closing comments

Many significant policy advances have taken place over the past few years to improve the quality of health care delivered in the UK. These advances have, rightly, been largely based on a scrutiny of the NHS workforce and an appraisal of its ability to deliver high quality care. However, sometimes, as these findings show, the political desire to challenge professional monopolies and break down traditional boundaries may have risked losing what is good about more longstanding systems of care and regulation.

These findings have highlighted the importance of reflection in developing new roles and services, to ensure that the current strengths in patient care are retained, while new ways of working replace what has become redundant in terms of patient need. Importantly, they highlight the value of reflective and consistent leadership by managers and practitioners to ensure that workforce matters are focused on patient need in its widest sense, and that at every stage of their journey through the NHS, patients and their families receive the highest quality care from the people best suited to provide it. It is my hope that the findings from this study feed into the debate about how best to achieve this important goal.

Appendix 1: Literature review tables

Table A1: Care co-ordinator studies

Author/ Year	Setting/ patient population	Study design	Educational and work background	Key duties	Key findings
Kay 1993	UK acute medical ward *In-patient setting*	Anecdotal. 2 posts.	Administrative *Non-registered[46]*	Ward clerking. Administration work from nursing e.g. booking ambulances, managing bed availability, maintaining ward stock, co-ordinating ward rounds, filtering general enquiries to ward.	Positively reported as instrumental in freeing up qualified nurses for patient care. No negative implications reported.
Reeves et al, 1999a; 1999b[47]	UK: Six acute medical wards *In-patient setting*	Qualitative exploratory pilot: 16 staff interviews and 2 observation sessions of ½ day each. 3 IPCC posts.	Administrative *Non-registered*	Ensuring timely clinical investigations; coordinating referrals to OT, physiotherapy and social work; gathering data on delays	Role highly valued by managers and colleagues. But role uncertainty, and potential inappropriate overlap into professional territory. These concerns reduced over time.
NHS Modernisation Agency 2003b	13 Changing Workforce Programme pilot sites across UK incorporating a wide range of redesigned roles. 3 care co-ordinator roles reported. *Includes in-patient setting(s)*	No details given of evaluative methods used	1. No details given of background of post-holders or training for role *Background not clear[48]* 2. Ward manager in role. No additional training apparent *Registered[49]* 3. No details given of background of post-holders or training for role *Background not clear*	1. Identifying and intervening with vulnerable older people with complex needs. One care co-ordinator role each in primary care, social care and acute care 2. Ensuring in-patient nursing assessment completed and care manager's assessment started. To improve communication and link with patient and relevant agencies 3. Emergency care co-ordinator to co-ordinate all activity in emergency care network. Also streaming patients and allocating resources.	1. Reduction in rate of readmissions rate cited. Need to clearly identify management lines for new roles 2. Significant reduction in delayed discharges cited. Positive feedback from patients and staff (unclear how gathered). 3. No evaluation reported
Addington-Hall et al. 1992; MacDonald,	UK: Terminally ill cancer patients	Randomised controlled trial. Postal survey to	Experienced and qualified district nurses or health	Assess need for and ensure provision of routinely available	59% potential professional colleagues not heard

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[46] Classified by researcher as non-registered worker(s).

[47] This study is the pilot study to the main study reported here.

[48] Insufficient details provided in study for researcher to determine whether worker(s) should be classified as registered or non-registered.

[49] Classified by researcher as registered worker(s).

Author/ Year	Setting/ patient population	Study design	Educational and work background	Key duties	Key findings
Addington-Hall & Anderson 1994	in inner London health district (post-discharge)	professional colleagues (n=500). Baseline interview with patients (n=281) and follow-up interview(s) (n=203). Post-bereavement interview with family (n=94). 2 posts	visitors *Registered*	services from different agencies. Provide link between patient, family and services. Acted as 'broker' for services	of service. Evaluated very positively by those professionals that had contact with service. No significant difference between treatment and control carers' perceptions of effectiveness of terminal care. Few significant clinical differences between the two groups. Nursing background may have constrained potential breadth to liaison role and lack of budget to obtain services may also have constrained effects.
Appleton et al. 1997	UK: Children with disability in transition to nursery school	Structured family (n=20) and care co-ordinator (n=8) interviews post-intervention. 12 posts	8 clinical medical officers, two social workers and two community nurses. Additional training received for role. *Registered*	Co-ordinating care and education. Provide structured assessment of child and family needs, care plan incorporating school transition plan, being available for parents throughout period of transition, co-ordinating case reviews.	Care co-ordinators identified they needed training in counselling skills, assessment, and client-centred working. Most families interviewed expressed satisfaction with service.
Dant & Gearing 1990	UK: Older people at risk of failing to cope at home	No details given of study design. Post-holders were 'under the gaze of a research team' (p. 349). 3 posts	'Degrees, teaching and nursing qualifications' (p. 348) *Registered*	Keyworkers – findings new ways of helping that did not necessarily rely on statutory services; attending to needs of carers	Different components of role described including in-depth assessment, arranging individualised packages of care, review of needs, provision of support through counselling (training provided to care co-ordinator for this) and advocacy.
Moher et al. 1992	Canada Two in-patient medical units. 1 post *In-patient setting*	Randomised controlled trial (n=267 patients). Included brief patient survey.	Baccalaureate nurse *Registered*	Facilitate discharge planning, co-ordinate tests and procedures, collect and collate patient information	Reduction in mean length of stay and improvement in satisfaction of treatment patients
Gow 1999	New Zealand In-patient medical ward. 1 post. *In-patient setting*	Pilot case-controlled (n=77 patients). Included patient survey (n not given) and staff (n=21) interviews	Registered nurse *Registered*	Facilitating patient movement to next point on continuum: assessment, speedy response to issues and problems; communicating who's doing what; avoiding discharge delays; staff education; ensuring timely referrals	Evaluated positively by staff and patients. Reduction in length of stay in treatment group.

Author/ Year	Setting/ patient population	Study design	Educational and work background	Key duties	Key findings
Counsell, Guin & Limbaugh 1994	USA In-patient neuroscience unit. 1 post *In-patient setting*	Pilot: analysis of critical path data gathered for 34 patients prior to project and 26 patients after intro of project. Included patient (n=33) and staff (n=21) survey.	Senior registered nurse with strong clinical background and excellent interpersonal skills. Additional training received for role. *Registered*	Facilitates care by ancillary services; coordinates multidisciplinary team conference when needed; resource person for staff; variance tracking of system problems; facilitator of patient care throughout stay; post-discharge follow-up	Small (not significant) difference in length of stay and cost. Patient satisfaction with communication and involvement remained strong following intro of project. Positive evaluation by staff.
Nichols & Zallar 1997	USA 6 posts across range of in-patient specialties *In-patient setting*	Quarterly management reporting data used to analyse changes in length of stay following intro of project (n not given). Anecdotal evidence of experience of introducing role.	Registered nurses with minimum 5 years clinical experience with equivalent education to bachelor's degree in nursing; also needed ability to function as team member, communication skills and specific clinical knowledge. Additional training received for role. *Registered*	Assessment and co-ordination of patient/family healthcare and education needs; collaboration with healthcare team to meet those needs; orchestration of discharge planning.	Initial role acceptance difficulties by staff members reported. Reduction in length of stay
Pryor 2003	Australia. In-patient rehabilitation service. Number of posts not stated *In-patient setting*	Pilot pre-test/post-test staff survey (n=40)	Not stated *Background not clear*	Not stated	Improvements reported in staff perceptions of patient admission, goal setting, team communication and patient discharge
Winstead-Fry, Bormolini & Keech 1995	USA 2 posts in family practice and internal medicine practice (both in-patient apparently) *In-patient setting*	'Evaluative comments' from care co-ordinators, staff and patients (n not given) and 'length-of stay data' (n=844, unclear how gathered). Quarterly activity reports submitted by care co-ordinators.	Nurses with exceptional clinical skills, communication skills, sensitivity to interpersonal dynamics, and 'experience and educational qualifications' (p. 49) *Registered*	Plan for discharge from day of admission; increase efficiency of physician rounds; improving interaction among patients, families and staff; continuous quality improvement	Statistically significant decreases in length of stay reported. Role evaluated positively.
Jamison et al. 1999	USA Medical – surgical in-patient unit. 1 post	Participant and non-participant observation (total hours not given), formal and informal staff interviews (n=17). Grounded theory approach to analysis	Registered nurse with minimum 2 years clinical experience and bachelor's degree in nursing	Development and implementation of care pathways and evaluation of patient outcomes	Issues reported of role ambiguity (lack of clarity) and the need to go through the process of 'making the role'. Making the role included communicating the vision, gaining new

Author/ Year	Setting/ patient population	Study design	Educational and work background	Key duties	Key findings
					knowledge (developing skills in leadership and IT, and knowledge in differentiated practice models, managed care, clinical pathways and insurance regulations), accessing resources and defining role boundaries. Activities around defining boundaries highlighted issues to do with flexibility versus clear expectations.
	In-patient setting		*Registered*		
Smith-Blair et al. 1999	USA Medical-surgical unit. 2 posts	Phenomenological: interviews with staff (n=11) supplemented with observations (32 hours) and documentary review	Described as nursing care co-ordinator role but no other information on background provided	Not stated	Context of constant change including other new roles and rising acuity of patients. Issues reported of role confusion, apprehension and fear (about role overlap), and struggling to make sense of role. Once familiarity with role grew, hope expressed about positive contributions of role.
	In-patient setting		*Registered*		

Table A2: Studies into generic roles

Author/ Year	Setting/ patient population/ role	Study design	Educational and work background	Key duties	Key findings
NHS Modernisation Agency 2003b	13 Changing Workforce Programme pilot sites across UK incorporating a wide range of redesigned roles. Generic roles reported include: 1. Healthcare practitioner on assessment unit 2. Healthcare practitioner assistant on assessment unit 3. Healthcare worker in primary care (early discharge worker) 4. Healthcare worker in hospital and community (stroke/neurological rehabilitation assistant) 5. Intermediate care development worker in intermediate care unit 6. Technical support worker (medical technician) 7. Generic rehabilitation assistant in community	Details of evaluative methods not given	1. Graduates of specialist six month, full-time postgraduate diploma 2. NVQ level 4 equivalent competency-based programme 3. A 'skilled support worker' 4. A 'skilled support worker with both rehabilitation and health skills experience' 5. No details given 6. and 7. Underpinned by education and training framework including work-based learning using training logs, policies and protocols and independent assessment of competence to perform tasks	1. Medical history and physical exam; order, perform and interpret diagnostic tests, diagnose and implement treatment plan; prescribes and administers medications; provides clinical interventions; assesses and plans for discharge 2. Routine observations and diagnostic tests (e.g. ECG, venepuncture) and clinical interventions (e.g. catheterise, pressure sore care); assess, educate and rehabilitate patients, assist with personal care and perform pre-discharge home assessment 3. Providing enhanced nursing and support care for a period of up to 3 weeks post-discharge in patient's own home or designated care setting 4. Supporting with the psychological effects of stroke; transferring patients to and from bed, chair, toilet; assisting dietary and fluid intake; carrying out care and treatment under guidance and delegation of stroke/neuro team; undertaking simple nursing procedures; assisting with medications 5. Admitting patients, goal setting and discharge planning 6. Patient observations, venepuncture, cannulation, ECGs, cleaning, bed making, equipment maintenance and escorting patients 7. Working autonomously and undertaking OT, physio, nursing and social care tasks within agreed parameters set by lead	1. and 2. Tensions within professional boundaries; advice on securing successful change in the face of resistance 3. 19 patients accepted on to scheme with 'only four' requiring an increase in their care package. Resistance to introduction of the role from therapy managers 4. Significant increases in average therapy time for patients and increases in Barthel[50] scores; improved efficiency of acute bed use 5. No evaluation reported 6. Fall in patient 'hand-offs'; reduced response time for diagnostic medical activities; 5.5 hours of nurse/doctor time freed over two months for more complex patient care and teaching 7. Rehabilitation goals achieved sooner with fewer physiotherapy, OT or social care contacts; social care packages reduced; patient 'hand-offs' reduced; physiotherapy, OT and nursing time freed up; Increase in Barthel score.
	Includes in-patient setting(s)		*Both registered and non-registered*		

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[50] A measure of physical functional independence.

Author/ Year	Setting/ patient population/ role	Study design	Educational and work background	Key duties	Key findings
				professionals. Simple patient observations. Assisting patients with fluid and dietary intake.	
Hurst 1995	8 in-patient units across UK. Multi-skilled and cross-trained staff. *In-patient setting*	Descriptive evaluation of patient-focused care using quantitative and qualitative data including non-participant observation (total hours not stated), informal interviews and meetings (with >80 'key workers'), and written questionnaires (n=8)	Implies support staff and nurses *Both registered and non-registered*	Staff working directly with patients take on wider range of skills.	Increase in proportion of staff time spent in direct care. Improved speed and efficiency of diagnostic investigations. Nurses wary about taking on low status tasks from medicine. Staff education key for multi-skilling and cross-training. Patient-focused care evaluated positively by staff.
Rolfe et al. 1999	UK in-patient rehabilitation service. Generic health care support worker. *In-patient setting*	Action research. All data collection at outset of role: 4 semi-structured group interviews with support workers (n=10) and registered staff (n=14). Visual analogue scale to measure attitudes to and satisfaction with service (n not given). 'Ethnographic snapshot over several days' (p. 328).	Support staff from variety of disciplines and clinical areas. Additional training to NVQ levels 2 and 3 provided. *Non-registered*	To provide coherent support for patient rehabilitation across nursing, physiotherapy and occupational therapy	Predictions of positive and negative consequences including issues of boundary overlap, unclear accountability and responsibility, training needs, dilution of competence and confidence of support workers, but also improved patient care and satisfaction.
Anderson 1997	Ward in UK acute hospital. Generic ward assistant *In-patient setting*	Ethnographic exploration of staff attitudes and perceptions to intro of new role over 7 weeks: semi-structured interviews (n=10), field diary, non-participant observation (total hours not given)	Ward assistant who undertook non-nursing activities such as errands off the ward and maintenance of supplies *Non-registered*	Carry out ward cleaning, catering and non-nursing duties	Initial uncertainties and tensions. After two weeks, improvement in ward environment and perception that nurses were being freed up for more direct care. Formal training programme required

Author/ Year	Setting/ patient population/ role	Study design	Educational and work background	Key duties	Key findings
Shield 2002	UK community rehabilitation and intermediate care teams. (Proposed) interprofessional practitioner for older people.	Surveys/interviews/meetings with clients (n=24), carers (n=22), staff and managers (n=150) from health and social services and interviews with representatives of professional bodies (n not given) to explore the potential of such a role and the associated educational requirements	Nationally accredited education and training perceived to be needed. Training at National Qualifications Framework and Higher Education Degree levels considered. *Non-registered*	To be a generalist in rehabilitation. Carers identified following needs: practical problem solving, communication, home visiting, information, equipment, someone to contact, financial advice	Positive support for the role being introduced. Training and education key. Existing rehab assistants felt not to have sufficient clout to get things done. Concerns raised about professional regulation of new roles as didn't fit existing professional groupings.
Pischke-Winn & Minnick 1996	US acute hospital *In-patient setting*	Anecdotal account of introducing multitask environmental workers	Employees in housekeeping and food and nutrition services *Non-registered*	Maintains clean environment; assists patients with nourishment; customer service communications (answering patient calls, 'phone etc.); assists nurse with patient care under direct supervision; stocks patient and unit supplies; assists in transport-related activities	Project leadership important. Post-holders and other staff needed in-service training. Multi-task worker-skills checklist and behavioural competency checklist used to evaluate
Nash, Grant & Bartolucci 2000	18 units in one US hospital. Patient care technicians (PCTs) and unit support specialists (USSs) *In-patient setting*	Range of pre-test/post-test measures across 5 of the units: salary costs, patient satisfaction (post-discharge questionnaire, n=1656), assessments of quality of nursing care (by observation, 4426 'time points' and pressure ulcer incidence, n=3167), and quality of employee work life questionnaire (n=350)	Background not stated. Competencies assessed against standard criterion measures *Background not clear*	PCTs undertake tasks previously done by respiratory (e.g. set up nasal cannula oxygen) and physical therapy (e.g. assist with simple ambulation), nursing (e.g. take vital signs), the laboratory (e.g. simple venepuncture) and heart station (perform EKGs). USSs: clean patient rooms, pass meal trays, transport discharged patients, and manage supplies.	Significant salary cost savings. No change in patient satisfaction, quality of care or quality of employee work life. Increase in nurse-patient contacts.
Principi et al. 1996	Canada. In-patient geriatric consultation team. Multiskilled assessors	Anecdotal description and evaluation	Geriatric team members (physiotherapist, OT, clinical nurse specialist,	To undertake multidimensional patient assessment and be case manager for that patient	Benefits cited include broadening experience and leaning of team members; cost

Author/ Year	Setting/ patient population/ role	Study design	Educational and work background	Key duties	Key findings
			geriatrician and family practitioner) who have, over time, developed ability to complete multidimensional assessment		effective; reduces number of people in direct contact with patient. But some expectations about professional role boundaries, and policies and procedures can constrain role blurring
	In-patient setting		*Registered*		

Table A3: Studies into other new roles that transcend traditional boundaries

Author/year	Setting/patient population/new role	Educational and work background	Study design
Read et al. 1999; Read 1998; Scholes, Furlong & Vaughan 1999	Range of new roles in nursing and professions allied to medicine (PAMs) in range of specialties in 40 acute Trusts throughout England. All posts studied had been in existence for at least six months. *In-patient setting*	All with nationally registered qualifications (with exception of operating department assistants/practitioners (ODA/Ps) holding posts open to both first level nurses and ODA/Ps) *Registered and non-registered*	Stage 1: mapping exercise to identify range and purpose of new roles. Combination of methods including interviews with nurse executive directors (n=36) or their representative (n=4), other senior staff (n not given), post-holders (n not given) and their managers (n not given); documentary review; and development of database of new roles (n=838) Stage 2: Set of 32 case studies to explore issues from stage 1 in more depth. Range of methods including participant and non-participant observation; semi-structured interviews; discussion groups; documentary review and review of Trust data Stage 3: Self-completion postal questionnaire to post-holders of all roles identified in stage 1
NHS Modernisation Agency 2003b	Range of new roles in range of health care settings established within national Changing Workforce Programme in 13 UK pilot sites *Includes in-patient setting(s)*	Range of backgrounds including administrative and registered practitioners *Registered and non-registered*	Success of new roles assessed by: Set targets for improving patient care Enhanced job satisfaction and staff retention Contribution to skills escalator concept Reduced vacancies and staff turnover No details given of how these measures were undertaken
Murray et al. 1997	Support workers in UK community mental health	Wide range of occupational backgrounds. 17% had either first or higher degree, often in the social, applied or technical sciences. 22% had qualifications equivalent to A levels, or skilled craft level. 23% had no qualifications. *Non-registered*	Semi-structured interviews with senior managers, mental health professionals, user representatives, representatives of professional colleges and training bodies, policy makers from user organisations, academics and trade union spokesperson (total n=50) Semi-structured interviews and individual caseload analysis with staff in 30 community mental health teams (n=62 support workers and 152 other staff) Semi-structured interviews with users (n=44)
Roe, Walsh & Huntington 2001; 2003	Nurses working in UK personal medical services (PMS) pilots	All registered nurses. 5 (out of 12) had nurse practitioner qualification; 7 were graduates, 2 currently working for master's degree. 3 had been health visitor previously and 1 had been district nurse. 4 had been practice nurses. *Registered*	12 nurses from first and second wave PMS pilots involved in series of 3 workshops using small and large group work to promote inquiry and reflection upon participants' experiences In-depth interviews with nurses and key stakeholders working in and with 4 case study sites (n=18)
Read & Graves 1994	New nursing posts funded to reduce hours worked by junior doctors in Trent region, UK	All registered nurses with mean of 12.7 years post-registration practice. Mode number of additional non-statutory qualifications=2 (range 0-7)	Multiple case study design Descriptive framework built up of each case (n=59) including setting, specialty, details of post-holder and training; practitioner record on how time is spent in role, details of patients, obstacles and helpful aspects to progress Interviews with post-holders, managers and some medical staff (n not given) Questionnaires to medical staff

Author/year	Setting/patient population/new role	Educational and work background	Study design
			(n=150) and some post-holders (n not given) Case profiles (n=32)
	Includes in-patient setting(s)	*Registered*	Audit and patient satisfaction data where available
Woods 1998	UK advanced nurse practitioners	Registered nurses studying at Masters level	Completion of role development diary by practitioners (n=13) in six months following completion of training course Longitudinal case study of 5 practitioners over 12 months of full-time training course and first six months after course completed: 2 semi-structured interviews with each of 5 practitioners
	Includes in-patient setting(s)	*Registered*	Approx. 50 hours each of observation of clinical practice of 3 practitioners (total 150h)

Appendix 2: Interview schedules

Interview schedule for exploration phase interviews and focus groups

Why do you feel the interprofessional care co-ordinator posts were created?

What roles and functions do you expect the care co-ordinators to undertake?

In your opinion, what are the advantages of having care co-ordinators in the multi-disciplinary team?

In your opinion, what are the disadvantages of having care co-ordinators in the multi-disciplinary team?

How do you think the care co-ordinator roles are viewed in general by nursing staff?

How do you think the care co-ordinator roles are viewed in general by medical staff?

How do you think the care co-ordinator roles are viewed in general by professions allied to medicine?

How do you think the care co-ordinator roles are viewed in general by the patients?

What issues or problems are there, if any, in relation to the management of the care co-ordinators?

What issues or problems are there, if any, in relation to the practice of the care co-ordinators?

What issues or problems are there, if any, in relation to the educational preparation for the care co-ordinators' role?

How would you judge the impact of the care co-ordinator role on patient care?

What changes, if any, would you make to improve the role and function of the care co-ordinators?

Are there any other issues related to the role and function of the care co-ordinators that you would like to cover?

Topic schedule for reflection phase interviews with operations managers

Benefits/outcomes of IPCC post

Future for the post

Organisational changes – implications for IPCCs and implications for interprofessional working

Evaluation of action research as an approach

Topic schedule for reflection phase interview with senior nurse

Changes since October 1998

?Attribute any changes to action research

Nursing context to study

Nursing roles in relation to IPCC role

Comment on action research as framework for change, as approach to research

IPCC documentation

IPCC scope of practice

Topic schedule for reflection phase interview with clinical director

Changes since October 1998

?Attribute any changes to action research

Comment on action research as framework for change, as approach to research

Appendix 3: Details of focus groups held

Focus group A (exploration phase)

Present:

12 social workers including 2 team leaders
Operations manager (IPCCs' manager)
Lead investigator (as facilitator)

Comments on group membership: All the social workers who worked for this local authority and worked in the Trust were invited and subsequently attended.

How discussions were initiated/guided: I began with a presentation of study findings to date, focusing particularly on feedback from the interviews with individual social workers and what had been learned about the activities of the IPCCs. The presentation led naturally into a discussion between the social workers and the IPCCs' manager. This was the first time that they had talked with each other about the IPCC role, and indeed about the wider priorities of their jobs.

Facilitator's role: to provide additional information when this was needed and to interject with the occasional question, but the discussions were very much led by the other participants. Also, to take a 'back-seat' role and allow discussions to develop naturally.

Length of session: 90 minutes

Location of session: Seminar room in hospital social work department

Mode of recording: Audio-tape

Focus group B (exploration phase)

Present:

5 dieticians
IPCC
Lead investigator

Comments on group membership: All the dieticians working in the Trust were invited along with the IPCCs. The IPCCs did not feel it was possible for them all to attend and so they chose a representative.

How discussions were initiated/guided: No interview schedule was used here, although I took a lead in getting interactions started and in occasionally interjecting with questions or seeking clarification. The group focused on exchanging information about the respective roles and priorities, and exploring areas in which the two groups could work more closely together to improve patient care.

Facilitator's role: To get discussions started and enable the exchange of information, and the planning of action. Also, to take a 'back-seat' role and allow discussions to develop naturally. To attend to group dynamics.

Length of session: 60 minutes

Location: Meeting room in dietetics department

Mode of recording: Facilitator's hand-written notes. Subsequently typed up and verified by participants.

Focus group C (exploration phase)

Present:

4 G grade nursing ward managers
Lead investigator (as facilitator)

Comments on group membership: All six ward managers working in the directorate were invited. Two could not attend because of clinical commitments.

How discussions were initiated/guided: A broad questionnaire was used to guide discussions (see Appendix 1) but discussions also followed leads from participants.

Facilitator's role: to use the pre-set questionnaire to gather information on the IPCC role and to use group discussion to explore perspectives on the role. Also, to attend to group dynamics and encourage all points of view.

Length of session: 60 minutes

Location: Seminar room on in-patient ward

Mode of recording: Audio-tape

Focus group D (exploration phase)

Present:

3 occupational therapists
Lead investigator

Comments on group membership: All three occupational therapists working in the directorate were invited and attended.

How discussions were initiated/guided: A broad questionnaire was used to guide discussions (see Appendix 1) but discussions also followed leads from participants.

Facilitator's role: to use the pre-set questionnaire to gather information on the IPCC role and to use group discussion to explore perspectives on the role. Also, to attend to group dynamics and encourage all points of view.

Length of session: 60 minutes

Location: Meeting room in occupational therapy department

Mode of recording: Facilitator's hand-written notes. Subsequently typed up and verified by participants.

Focus group E (action phase, workshop 1)

Present:

3 IPCCs
2 doctors (clinical director and SHO)
Trust director of therapies
4 nurses (directorate head of nursing, 2 other registered nurses, health care support
     worker)
2 physiotherapists
Occupational therapist
Social worker
5 researchers (including lead investigator)
4 'external participants' (1 director of nursing education, 1 barrister, 2 individuals
     from other Trusts with senior remits for health care support worker training
     and support)

Comments on group membership: This focus group was one of five focus groups that took place within the interprofessional development workshop on 'Exploring issues of accountability'. Representation was sought for all the professional groups working with the IPCCs as well as the IPCCs themselves. Initially, one representative was sought from each group, but all the IPCCs wished to attend (one could not subsequently because of sickness) and the physiotherapists wanted representation for both respiratory and neurological physiotherapy specialties. A variety of means were used to select individual practitioners to attend. For example, one ward manager was chosen to represent the ward nursing viewpoint because she had shown a particular interest in the IPCC role and held strong views. The physiotherapists were invited because they had both been previously involved in the study and their presence provided continuity. The occupational therapist attended after an invitation was issued to her department to send a representative.

Representation of managers was also sought. The service's senior nurse could not attend because of annual leave. External participants were selected for the expertise they could offer in topic areas relevant to the workshop focus.

How discussions were initiated/guided: Prior to the workshop, each participant received a briefing paper (see Appendix 7). At this focus group, I presented the study findings to date that had emerged in relation to the accountability of the IPCCs. Discussions that followed focused on the accountability of the different members of the health care team.

Facilitator's role: Another researcher and I jointly facilitated this discussion to ensure each professional grouping represented had an opportunity to contribute. The short length of the session meant that in-depth discussions were not possible.

Length of session: 30 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape

Focus group F (action phase, workshop 1)

Present:

Director of nursing education (from outside Trust) (group facilitator)
2 senior physiotherapists
Senior occupational therapist
3 IPCCs
Social worker
Ward manager (nurse)
Senior house officer (doctor)
Researcher (observer)

Comments on group membership: This focus group was one of five focus groups that took place within the interprofessional development workshop on 'Exploring issues of accountability'. Members of this group were IPCCs and practitioners who worked alongside the IPCCs.

How discussions were initiated/guided: Prior to the workshop, each participant received a briefing paper (see Appendix 7). At this focus group, participants were asked to address the following questions:

> Do the IPCCs have a discrete area of practice or is their work always delegated from other health professionals?

> How do the IPCCs negotiate with the other health professionals what it is that they do?

> What assurances do the health professionals have that delegated work to the IPCCs is carried out within agreed parameters?

> What systems, if any, are currently in place for communication, reporting back, documentation, patient screening, referral? Does everyone know about these systems?

Facilitator's role: To use the pre-set questionnaire to guide discussions. To attend to group dynamics and ensure that everyone's point of view was heard. The short length of the session meant that in-depth discussions were not possible.

Length of session: 20 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape and observer's hand-written notes.

Focus group G (action phase, workshop 1)

Present:

Researcher (facilitator)
Researcher (observer)
Researcher (lead investigator as group participant)
Clinical director (doctor)
Directorate head of nursing
Trust director of therapies
Barrister

Comments on group membership: This focus group was one of five focus groups that took place within the interprofessional development workshop on 'Exploring issues of accountability'. Members of this group were selected to address issues of managerial concern.

How discussions were initiated/guided: Prior to the workshop, each participant received a briefing paper (see Appendix 7). At this focus group, participants were asked to address the following questions:

Who is accountable for the IPCCs? Are there opportunities to clarify accountability?

What are the current Trust/directorate systems for monitoring and regulating the work of all employees (in issues like confidentiality, scope of practice, etc.)? With a role like the IPCCs' role (where individuals are not registered professionals and yet have an important degree of autonomy in their work, and possible influence on patient care) are the current systems adequate?

Where different professional groups contribute to an aspect of patient care e.g. planning the discharge of Mrs C, who is to be held accountable if the discharge fails? Is the notion of team accountability worth exploring?

What lessons would you want to pass on to other organisations setting up similar roles?

What, if anything, needs to be addressed next?

Facilitator's role: To use the pre-set questionnaire to guide discussions. To attend to group dynamics and ensure that everyone's point of view was heard. The short length of the session meant that in-depth discussion was not possible.

Length of session: 20 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape and observer's hand-written notes.

Focus group H (action phase, workshop 1)

Present:

Researcher (facilitator)
Health care support worker (HCSW)
Directorate clinical support nurse for HCSWs
2 individuals from other Trusts with interest/expertise in HCSW support and
       education

Comments on group membership: This focus group was one of five focus groups that took place within the interprofessional development workshop on 'Exploring issues of accountability'. Members of this group were selected because of their interest and experience in the support and training of health care support workers.

How discussions were initiated/guided: Prior to the workshop, each participant received a briefing paper (see Appendix 7). At this focus group, participants were asked to address the following questions:

       What are the issues that we need to consider in relation to the training, development and supervision of IPCCs?

       How is competence assured in the absence of direct supervision?

       Should we pursue professional status for the IPCCs or should they be a licensed workforce?

       To what extent is the introduction of IPCCs responding to the needs of patients or the needs of service? How can we assure quality of patient care and the non-exploitation of IPCCs?

Facilitator's role: To use the pre-set questionnaire to guide discussions. To attend to group dynamics and ensure that everyone's point of view was heard. The short length of the session meant that in-depth discussions were not possible.

Length of session: 20 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape and facilitator's hand-written notes.

Focus group I (action phase, workshop 1)

Present:

3 IPCCs
2 doctors (clinical director and SHO)
Trust director of therapies
4 nurses (directorate head of nursing, 2 other registered nurses, health care support
     worker)
2 physiotherapists
Occupational therapist
Social worker
5 researchers (including lead investigator)
4 'external participants' (1 director of nursing education, 1 barrister, 2 individuals
     from other Trusts with senior remits for health care support worker training
     and support)

How discussions were initiated/guided: This focus group was one of five focus
groups that took place within the interprofessional development workshop on
'Exploring issues of accountability'. Prior to the workshop, each participant
received a briefing paper (see Appendix 7). Prior to this focus group, focus groups
E-H were held. At this focus group, focus groups F, G and H (see above) were
invited to feed back their discussions. This then led to a discussion of the main
issues emerging, including some action planning to address the issues raised. The
absence of a questionnaire for this session enabled participants to guide the focus
of the discussion to issues of concern to them.

Facilitator's role: Another researcher and I jointly facilitated this discussion to
ensure each professional grouping represented had an opportunity to contribute.
Group dynamics were also attended to and efforts were made to maximise equal
representation, although the size of the group meant that full participation by
everyone could not be achieved.

Length of session: 45 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape

Focus group J (action phase, workshop 2)

Present:

5 nurses (directorate senior nurse, 3 ward managers, and HCSW clinical support
        nurse)
Senior OT
Social work team leader
Senior house officer (doctor)
2 physiotherapists (1 senior, 1 junior)
IPCC
2 researchers (one facilitator and one observer)

Comments on group membership: This focus group was one of three focus groups
that took place within the interprofessional development workshop on 'Improving
interprofessional working'. Representation was sought at the workshop for all the
professional groups working with the IPCCs as well as the IPCCs themselves.
Membership was similar to that of the first interprofessional development
workshop, except that more nurses were invited to this second workshop. Many
issues to do with nursing and interprofessional working had emerged from study
findings, and it was felt that all ward managers should be invited to attend because
of this. Three were unable to attend because of other commitments. One IPCC
could not attend because of annual leave. Representation of managers was also
sought but, because the focus was on practice, practitioners formed the majority of
the participants. Focus Groups J and K were formed by splitting the workshop
participants into two groups of roughly equivalent membership in terms of number
and profession.

How discussions were initiated/guided: Prior to the workshop, each participant
received a briefing paper (see Appendix 8). An introductory session was held with
participants from groups J and K (see below for group K membership). The
introductory session consisted of presentations of study findings on
interprofessional working from me and a research fellow also conducting an
unrelated study on interprofessional working in the directorate. An officer from the
local community health council also gave a presentation on interprofessional
working from the user's perspective.

Following these presentations, participants were split into two groups. Group J
was asked by its facilitator to address the following questions:

> What are the key issues that came out of the presentations that you think
> need to be focused on?

> What other issues are there that haven't been addressed in the
> presentations?

> What are the top three priority issues that need to be sorted out to move
> things forward?

Facilitator's role: Another researcher (not myself) facilitated this session. Their
role was to use the pre-set questionnaire to guide discussions, and to attend to

group dynamics and ensure that everyone's point of view was heard. The short length of the session meant that in-depth discussion was not possible.

Length of session: 20 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape and observer's hand-written notes.

Focus group K (action phase, workshop 2)

Present:

3 nurses (fast response team leader, ward manager, ward sister)
2 IPCCs
Senior physiotherapist
Trust director of therapies
Clinical director (doctor)
2 researchers (one facilitator and one observer)

Comments on group membership: This focus group was one of three focus groups that took place within the interprofessional development workshop on 'Improving interprofessional working'. Representation was sought at the workshop for all the professional groups working with the IPCCs as well as the IPCCs themselves. Membership was similar to that of the first interprofessional development workshop, except that more nurses were invited to this second workshop. Many issues to do with nursing and interprofessional working had emerged from study findings, and it was felt that all ward managers should be invited to attend because of this. Three were unable to attend because of other commitments. One IPCC could not attend because of annual leave. Representation of managers was also sought but, because the focus was on practice, practitioners formed the majority of the participants. Focus Groups J and K were formed by splitting the workshop participants into two groups of roughly equivalent membership in terms of number and profession.

How discussions were initiated/guided: Prior to the workshop, each participant received a briefing paper (see Appendix 8). An introductory session was held with participants from groups J and K (see above for Group J membership). The introductory session consisted of presentations of study findings on interprofessional working from me and from a research fellow also conducting an unrelated study on interprofessional working in the directorate. An officer from the local community health council also gave a presentation on interprofessional working from the user's perspective.

Following these presentations, participants were split into two groups. Group K was asked by its facilitator to address the following questions:

What are the key issues that came out of the presentations that you think need to be focused on?

What other issues are there that haven't been addressed in the presentations?

What are the top three priority issues that need to be sorted out to move things forward?

Facilitator's role: Another researcher (not myself) facilitated this session. Their role was to use the pre-set questionnaire to guide discussions, and to attend to group dynamics and ensure that everyone's point of view was heard. The short length of the session meant that in-depth discussion was not possible

Length of session: 20 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape and observer's hand-written notes.

Focus group L (action phase, workshop 2)

Present:

3 IPCCs
8 nurses
2 doctors
3 physiotherapists
Occupational therapist
Social worker
Trust director of therapies
5 researchers (including lead investigator)
6 'external participants': Officer from local community health council, research fellow from second study on interprofessional working in directorate, senior nurse from trauma and orthopaedics directorate in Trust, project co-ordinator of team-based learning project in another health authority, professor of nursing from another university with research record in interprofessional working, researcher from City University with research record in interprofessional education.

Comments on group membership: This focus group was one of three focus groups that took place within the interprofessional development workshop on 'Improving interprofessional working'. Representation was sought at the workshop for all the professional groups working with the IPCCs as well as the IPCCs themselves. Membership was similar to that of the first interprofessional development workshop, except that more nurses were invited to this second workshop. Many issues to do with nursing and interprofessional working had emerged from study findings, and it was felt that all ward managers should be invited to attend because of this. Three were unable to attend because of other commitments. One IPCC could not attend because of annual leave. Representation of managers was also sought but, because the focus was on practice, practitioners formed the majority of

the participants. External participants were selected for the expertise they could offer in topic areas relevant to the workshop focus.

How discussions were initiated/guided: Prior to the workshop, each participant received a briefing paper (see Appendix 8). Following the introductory session, groups J and K were held. All participants and external participants were brought together for focus group L. Groups J and K fed back on their discussions, and presentations on interprofessional working were then given by the four external participants who had not yet presented: senior nurse from trauma and orthopaedics directorate in Trust, project co-ordinator of team-based learning project in another health authority, professor of nursing from another university with research record in interprofessional working, researcher from City University with research record in interprofessional education.

After these presentations, participants were invited to make comments or queries addressed to their colleagues or any of the presenters. A group discussion then emerged.

Facilitator's role: Another researcher and I jointly facilitated this discussion to ensure each professional grouping represented had an opportunity to contribute. Group dynamics were also attended to and efforts were made to maximise equal representation, although the size of the group meant that this was not possible. The absence of a questionnaire for this session enabled participants to guide the focus of the discussion to issues of concern to them.

Length of session: 45 minutes

Location: Seminar room in the Trust

Mode of recording: Audio-tape and observer's notes

Focus group M (action phase)

Present:

Trust director of therapies
Senior physiotherapist
Senior dietician
Senior occupational therapist
Senior speech and language therapist
Lead investigator (as facilitator)

Comments on group membership: Representation was sought from each of the therapy professions working in the directorate. Senior representation was preferable as these therapists had been at the Trust longer than the junior therapists and so could provide an overview of changes over time with regard to the IPCC role.

How discussions were initiated/guided: In advance of the group, participants were sent a copy of the aims which were:

> To update them on the progress of the project

> To give an opportunity for the therapies to formally update the project findings on the nature of their work with the IPCCs

> To discuss the proposal for multidisciplinary workshops in the first six months of 2000 on the main project themes emerging (accountability between professional and non-professional roles, multidisciplinary team meetings, introducing new roles, the role of the IPCC), and give those present an opportunity to comment on the focus and membership of those workshops.

I began with a summary of findings to date, focusing particularly on those of relevance to the therapists. A general discussion then followed on the IPCCs' contact and work with therapists.

Facilitator's role: I interjected with the occasional question or process point, but once the discussion had started the therapists guided the focus. They asked me questions as well. In contrast to the other focus groups, this group met together regularly outside of the action research study, and it appeared that this led to more relaxed proceedings.

Length of session: 60 minutes

Location: Meeting room in Trust

Mode of recording: Audio-tape

Focus group N (reflection phase)

Present:

Clinical director (doctor)
Senior nurse
2 senior physiotherapists
Ward manager (nurse)
Senior OT
2 IPCCs
Pharmacist
3 researchers (including lead investigator)

Comments on group membership: Everyone who had taken part in focus groups J and K were invited to this focus group (with the exception of the external participants), but clinical commitments meant that not everyone could attend.

How discussions were initiated/guided: The group were asked to address the following questions:

Revisit priorities that came from workshop on 'Improving interprofessional working'

Are these the priorities you want to address?

Have any other priorities emerged since the last meeting?

In relation to the priorities:

> What do you feel could be done, by you, to take things forward?
>
> What support, if any, would you like to do this?
>
> What do you feel could be done by others to take things forward?
>
> What support, if any, would they need to do this?

Identify concrete action plans

What happens next?

Who is involved?

What is the planned timescale?

In spite of the question schedule, discussions were allowed to develop freely. All the participants had taken part in previous focus groups in the study and this appeared to enable more relaxed contributions.

Facilitator's role: The group was not facilitated by me, but by another researcher. I took part in discussions, while a third researcher operated the tape recorder, took notes and also joined in.   The facilitator's role was to use the questionnaire as a starting point for discussions led by the group and for action planning for practice developments.

Length of session: 90 minutes

Location: Meeting room in Trust

Mode of recording: Audio-tape and observer's notes

Focus group P (reflection phase)

Present:

4 IPCCs
Researcher (as facilitator)

Comments on group membership: All four IPCCs were invited and were present.

How discussions were initiated/guided: A brief questionnaire was used to guide discussions, but discussions were allowed to develop naturally. Questions asked were:

> What changes have occurred since October 1998 when this study began?
>
> What (if any) changes would you attribute to the action research study?

What do you think of action research as an approach?

Facilitator's role: Another researcher (not me) facilitated this session. Her role was to use the questionnaire to initiate discussions with the IPCCs, and to attend to group dynamics and ensure everyone's point of view was represented.

Length of session: 30 minutes

Location: IPCCs' office

Mode of recording: audio-tape

Appendix 4: List of nodes in NUD*IST index system

Q.S.R. NUD.IST Power version, revision 4.0.

PROJECT: Care Co-ordinator, User Jackie, 2:10 pm, Oct 16, 2002.

```
(1)            /Case Data
(1 1)           /Case Data/gender
(1 1 1)          /Case Data/gender/male
(1 1 2)          /Case Data/gender/female
(1 1 3)          /Case Data/gender/DK
(1 2)           /Case Data/Prof Gp
(1 2 1)          /Case Data/Prof Gp/CCs
(1 2 1 1)         /Case Data/Prof Gp/CCs/CC1vws
(1 2 1 2)         /Case Data/Prof Gp/CCs/CC2vws
(1 2 1 3)         /Case Data/Prof Gp/CCs/CC3vws
(1 2 1 4)         /Case Data/Prof Gp/CCs/CC4vws
(1 2 1 5)         /Case Data/Prof Gp/CCs/CC5vws
(1 2 1 6)         /Case Data/Prof Gp/CCs/CCgpvws
(1 2 2)          /Case Data/Prof Gp/Nurses
(1 2 3)          /Case Data/Prof Gp/Doctors
(1 2 4)          /Case Data/Prof Gp/managers
(1 2 5)          /Case Data/Prof Gp/OT
(1 2 6)          /Case Data/Prof Gp/Physio
(1 2 7)          /Case Data/Prof Gp/SocWkr
(1 2 8)          /Case Data/Prof Gp/WrdClrks
(1 2 9)          /Case Data/Prof Gp/S&LDiet
(1 2 10)         /Case Data/Prof Gp/Other
(1 2 11)         /Case Data/Prof Gp/IP group
(1 3)           /Case Data/Time
(1 3 1)          /Case Data/Time/118-019
(1 3 2)          /Case Data/Time/029-049
(1 3 3)          /Case Data/Time/059-079
(1 3 4)          /Case Data/Time/089-109
(1 3 5)          /Case Data/Time/119-010
(1 3 6)          /Case Data/Time/020-040
(1 3 7)          /Case Data/Time/050-070
(1 4)           /Case Data/DataType
(1 4 1)          /Case Data/DataType/obs
(1 4 2)          /Case Data/DataType/intrvw
(1 4 3)          /Case Data/DataType/other
(1 4 4)          /Case Data/DataType/field nots
(2)            /CCs
(2 1)           /CCs/IndCases
(2 1 1)          /CCs/IndCases/CC1abt
(2 1 2)          /CCs/IndCases/CC2abt
(2 1 3)          /CCs/IndCases/CC3abt
(2 1 4)          /CCs/IndCases/CC4abt
(2 1 5)          /CCs/IndCases/FRTCCabt
(2 2)           /CCs/About CC Role
(2 2 1)          /CCs/About CC Role/What CC does
(2 2 1 1)         /CCs/About CC Role/What CC does/Tasks
(2 2 1 1 1)        /CCs/About CC Role/What CC does/Tasks/A&E
(2 2 1 1 2)        /CCs/About CC Role/What CC does/Tasks/Qual unique
(2 2 1 2)         /CCs/About CC Role/What CC does/Characteristics
(2 2 1 2 1)        /CCs/About CC Role/What CC does/Characteristics/hardening boundaries
(2 2 1 2 2)        /CCs/About CC Role/What CC does/Characteristics/Boundaries to role
(2 2 1 2 2 6)       /CCs/About CC Role/What CC does/Characteristics/Boundaries to role/Bounda mns Terr
and Char
```

```
(5 1)              /Contextual/H&S care interface
(5 2)              /Contextual/Acute pressures
(5 3)              /Contextual/Trust re-org
(5 4)              /Contextual/Nursing shortage
(6)             /Research
(6 1)            /Research/Views on AR
(6 2)            /Research/Ethical issues
(6 3)            /Research/Outcomes
(6 4)            /Research/Planned d'ments
(6 5)            /Research/My role
(D)             //Document Annotations
(F)             //Free Nodes
(F 1)            //Free Nodes/Playing
(F 1 1)           //Free Nodes/Playing/SWs
(F 1 1 1)           //Free Nodes/Playing/SWs/R'ship mns terr
(F 1 2)           //Free Nodes/Playing/Nurses
(F 1 3)           //Free Nodes/Playing/Docs
(F 2)            //Free Nodes/Topics
(F 2 1)           //Free Nodes/Topics/FRT
(F 2 2)           //Free Nodes/Topics/discharge delays
(F 2 3)           //Free Nodes/Topics/personality
(F 2 4)           //Free Nodes/Topics/Future
(F 2 5)           //Free Nodes/Topics/Misc
(F 2 6)           //Free Nodes/Topics/Docs and nurses
(F 2 7)           //Free Nodes/Topics/Interest from other hosps
(F 2 8)           //Free Nodes/Topics/readmissions
(F 2 9)           //Free Nodes/Topics/lack of prof background
(F 2 10)           //Free Nodes/Topics/new roles
(F 2 11)           //Free Nodes/Topics/Directorate
(F 2 12)           //Free Nodes/Topics/docs and mgrs
(F 2 13)           //Free Nodes/Topics/HCSWs
(F 2 14)           //Free Nodes/Topics/Elderly Care
(F 2 15)           //Free Nodes/Topics/NHome placement
(F 2 16)           //Free Nodes/Topics/discharge checklist
(F 2 17)           //Free Nodes/Topics/Independent practice
(F 2 18)           //Free Nodes/Topics/pt assessments
```

Figure A1   Excerpt from NUD*IST coding tree
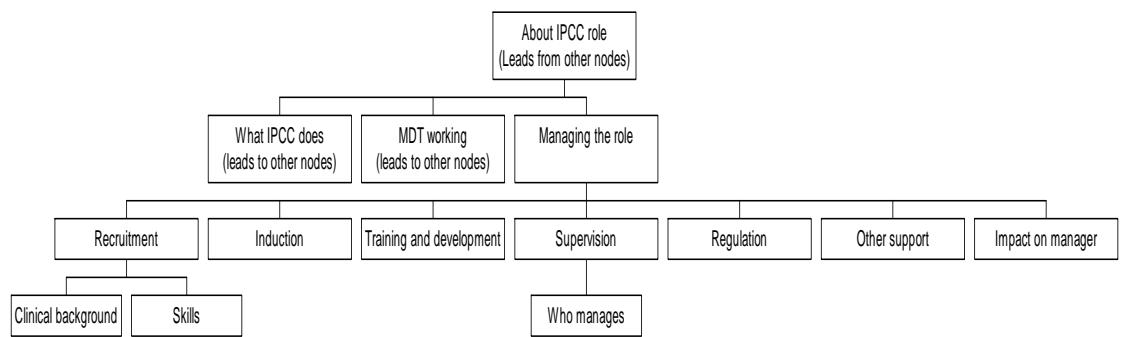
Appendix 5: IPCC job description and person specification

**JOB DESCRIPTION FOR
INTERPROFESSIONAL CARE CO-ORDINATOR
IN MEDICAL AND EMERGENCY DIRECTORATE**

Responsible to: Operations Manager, Medical and Emergency

Accountable to: Operations Manager, Medical and Emergency

Job Purpose:

To work in a collaborative manner with medical and nursing teams, social work and other departments, under the direction of the Operations Manager, Medical and Emergency, to ensure in-patient stays are co-ordinated, so that length-of-stay for individual patients is dictated only by clinical need and not delayed for organisational reasons. Thus the postholder will chiefly facilitate appropriate and timely discharge, acting as the patient's advocate in this regard.

Key Tasks

A.   Patient Management

   1.   Maintain a detailed and accurate list of in-patients by consultant/firm

   2.   Identify potential handbacks/MRSA[51] exposure

---

[51] Multi-resistant staphylococcus aureus

3.   Liaise with staff on a daily basis, where appropriate attending the post-take and general ward rounds with the medical teams, so as to update patient management/treatment plans, seek advice and forewarn of likely discharge problems

4.   Develop co-operative relationships with support Directorates to ensure timely access to investigations

5.   Establish co-operative relationships with Diagnostic Imaging and the Health Records Department to ensure x-rays and medical notes are available within twelve hours of admission and thereafter throughout the patient's stay

6.   Work with the Ward Administrators to ensure that tracking systems exist for missing notes/x-rays, and assist in searches when required

7.   Collect and screen Social Service referrals

8.   Liaise with social workers and community services to facilitate timely discharge of patients back to the community or other appropriate facility

9.   Ensure consultant referrals are expedited

10.   Liaise with GP and primary care services to ensure accuracy of patient information and home needs

Work with ward clerks to ensure continued accuracy of PAS data and GP data

Work with medical secretaries to ensure that discharge summaries are produced in a timely fashion, in accordance with Purchaser specifications

13.   Ensure that patient confidentiality is maintained at all times

14.   Liaise with patient's family regarding existing and future care needs

15.   Participate in monthly audit topic

B.   Record Keeping

     1.   Work with the Ward Administrators to ensure accurate information concerning patient admission is recorded on the front sheet. Ensure any changes are updated

     2.   Record and collate information relating to patients whose hospital admission is prolonged

     3.   Assist with data collection for audit and other purposes

     4.   Develop computer skills

C. Teamwork

     1.   Work in a collaborative fashion with other Care Co-ordinators and clinical staff

     2.   Seek opportunities to build relationships with other care professionals to facilitate best care

     3.   Assume responsibility for covering other Firms in the event of sickness or annual leave of other Care Co-ordinators.

The postholder must be aware of individual responsibilities under the Health and Safety at Work Act, and identify and report as necessary any untoward accident, incident or potentially hazardous environment

This job description may alter in response to service needs and following discussion with the post holder.

August 1998

PERSON SPECIFICATION for INTERPROFESSIONAL CARE CO-ORDINATOR IN MEDICAL AND EMERGENCY DIRECTORATE

	Essential	Desirable
Detailed working knowledge of hospital environment	✓	

Professional qualification
  e.g. RGN[52]
      AMSPAR[53]
		✓

Methodical approach to work	✓	
Team worker	✓	
Proven ability to prioritize work	✓	
Previous experience of maintaining records		✓
Previous experience of keeping statistical information Involvement in research/audit		✓ ✓
Knowledge of PAS	✓	
Kind and courteous approach to people	✓	

---

[52] Registered general nurse
[53] Qualification from Association of Medical Secretaries, Practice Managers, Administrators and Receptionists

Appendix 6: Comparison between IPCC practice and job description

Category	Activity
Covered in job description and reflected in observation/ interview data	Taking on administrative duties from interprofessional team colleagues
	Working independently or with interprofessional team members to identify those patients at risk of a delayed discharge early on in admission
	Predicting and prompting 'next steps' by interprofessional team members for a patient's passage
	Making sure referrals get sent early
	Overseeing and co-ordinating the path of 'at risk' patients through admission and discharge
	Collecting and verifying information about patients
	Lobbying post-discharge services to take patients soon
	Liaising with out-of-borough social workers
	Liaison with patient's family
	Giving information to patient's family
	Checking with team members that plans for discharge are okay
	Collecting information about other services
	Being available to interprofessional colleagues to provide information to them about patients and services
	Giving information to directorate managers about delayed discharges
Covered in job description but not reflected in observation/ interview data	Attending post-take and general ward rounds
	Developing co-operative relationships with diagnostic imaging and health records departments to ensure speedy retrieval of medical notes and X-rays
	Working with ward clerks to develop tracking systems for missing medical notes and X-rays, and assist in searches where necessary
	Working with ward clerks to ensure accurate information is recorded on patient's front sheet and updating changes
	Working with medical secretaries to ensure timely discharge summaries
Not covered in job description but reflected in observation/ interview data	Chasing up and instructing professionals to encourage their timely input
	Liaising between interprofessional team members
	Doing last-minute tasks before discharge or carrying out unique tasks that would usually be no-one's responsibility
	Ensuring weekly interprofessional meetings take place
	Ensuring team members tell each other things
	Collecting pre-admission information from patients and families
	Interpreting information gathered and initiating plan of action
	Deciding referrals to social work and OT by interprofessional colleagues are not needed and filtering them

Category	Activity
	Initiating referrals to other team members
	Re-starting home care services when level of service remains unchanged
	Filtering and selectively giving information to interprofessional team members and other care providers about patients and services
	Giving information to patients
	Carrying out additional tasks that enhance patients' sense of well-being e.g. making sure patient's dog is cared for
	Being a key point of contact for some patients and their families

Appendix 7: Briefing paper for workshop 1

A focus group to explore issues of accountability at the boundary between professional and non-professional care

<u>Participant preparation</u>

Thank you for agreeing to attend the above focus group which is part of the Medical and Emergency Directorate's action research study on the co-ordination of interprofessional care, a study which focuses on the role of the interprofessional care co-ordinators.

We would be grateful if you could do the following before the focus group:

1.   Read the enclosed briefing paper (which represents notes we hope will initiate debate).

2.   Consider accountability, responsibility and authority within your own profession. (If you have any key documents by your profession which help to define or explore these concepts, please bring them along to the workshop or send them later)

3.   Discuss with colleagues in your professional group the questions raised on page 10 of this document and come along prepared to represent the opinions of your professional group.

If you do not have time to do this before the focus group, we are happy to receive any submissions up until mid-March which represent your views and/or the views of your colleagues. Send them to Jackie Bridges, *(address)* or call her on *(telephone number)*.

The focus group will be held on Tuesday 15 February, 2.00-4.30 p.m. in the *(location and directions)*. Please try to arrive for a prompt start.

Please note we are planning to tape record the proceedings to use as study data. Please let us know in advance if this is a problem.

If you cannot come at the last minute, please try and send someone in your place and let Jackie know (*telephone number*).

A focus group to explore issues of accountability at the boundary between professional and non-professional care

Participants

Group A

Registered nurse
IPCC
SHO
OT
Social worker
Physiotherapist
Director of Nursing Education from *X organisation*

Group B

Head of Nursing, Medical & Emergency directorate
Medical consultant
Trust Director of Therapy Services
Tower Hamlets Social
   Services Team Manager
Barrister

Group C

HCSW
Clinical Support Nurse
HCSW Trainer, *X Hospital NHS Trust*

A focus group to explore issues of accountability at the boundary between professional and non-professional care

Participant Briefing Notes

Introduction

An action research study is currently being conducted to explore the co-ordination of interprofessional care. The study is based in the Medical and Emergency directorate at a large UK Trust and seeks to evaluate and further improve a brand new role in health care, that of IPCC. Each of the directorate's four IPCCs is linked to two medical teams and follows patients through from admission to discharge, seeking to unblock any problems which may keep a patient in longer than necessary (e.g. waiting for old medical notes or test results, or delays in nursing home placement) and to act as a central communicator of 'what is going on' for an individual patient to members of the multidisciplinary team. The IPCCs come from mainly administrative backgrounds, and do not have formal health or social care qualifications.

Collection of a range of qualitative and quantitative data within the study has focused on describing the differing roles the individual IPCCs have developed since their inception three years ago, and on exploring the impact of the role both within the in-patient multidisciplinary team and on patient experience.

Data have emerged from the work that have thrown light on the wider issue of accountability at the professional/ non-professional interface. There is a need to explore this further. This multidisciplinary workshop aims to initiate debate, reach clarification where this is achievable and set an agenda for further action that is needed.

Broad aims of the focus group

To explore:

the boundary between trained professional and 'non-professionals' and their contributions to patient care

the protective mechanisms that need to be in place, in terms of patients receiving best care, and professional accountabilities in law and to their regulatory bodies

whether levels of competence and occupational standards presents a more useful framework for training, development and supervision.

National Context to the Work

Major changes are occurring in UK health care which are leading to subsequent changes in the roles of health care professionals. Whilst there have been pronounced changes in the roles of professionals there has been little evaluation of the impact of these changes on patient care and outcomes (Buchan et al, 1997). As professional activity diversifies and evolves in response to change, the extent to which 'traditional' activities should be retained by professionals or delegated to support workers is increasingly being debated. It has been suggested that many tasks undertaken by qualified staff are not directly related to patient care and that support workers could fulfil these indirect and associated tasks. Indeed the roles of these support workers are evolving. Within nursing literature, there remains a gap in research about the effect of such changes on patient care and outcome. However, research does suggest that there is little difference in the amount of direct care given by grades of nurses (Dewar, 1992). Research indicates that nurses have an important role to play in the supervision and support of health care assistants (Ahmed and Kitson, 1993; Thomas, 1993; Reeve, 1994; Thomas 1994; Edwards, 1997) yet this is not always achieved in practice (Rhodes, 1994).

Protective mechanisms and the principle of accountability

Issues of accountability apply to all professions. Accountability has been defined in nursing as "the requirement that each nurse is answerable and responsible for

the outcome of his or her professional actions" (Pennels, 1997). Since accountability is an integral part of practice it is associated with the following:

Patient's have an expectation that by virtue of a nurse's training and position, the nurse will be answerable to the patient while he/she is in their care;

That since accountability arises from training and education, this explains why the notion is present in some jobs and not others. Knowledge from training is therefore essential in order to explain why an event took place;

Since accountability and authority are interdependent, a greater degree of accountability is expected of those with greater authority.

Delegation

Professionals are accountable for the decision to delegate and for ensuring that the task delegated has been undertaken. Support workers are often delivering skilled tasks and their competence therefore needs to be assured by those who delegate, and their work should be monitored by those who remain accountable for that work (i.e. the delegators of that task). However lack of definition of role for support workers can make it difficult to determine the education required for them to carry out their duties competently and safely.

Consent

When patients are cared for by a professional they can expect that the information that they provide will be used properly and in a confidential manner. This expectation arises from expecting the professional to have achieved a certain level of practice through training and education and in addition through the code of conduct for that professional. When cared for by non-professionals there are no such guarantees. Indeed there are issues about how such workers gain consent from patients.

Clinical Governance

The principle of clinical governance re-inforces Trust responsibility for the quality of care delivered by employees (Department of Health, 1998). Part of this must be organisational responsibility for ensuring appropriate mechanisms are in place for

the training, development, and regulation of those employees involved in direct patient care.

Regulation of non-professional workers

There are increasing numbers of non-professionals being employed within health care to replace more highly qualified professional workers.   There is little consistency in the job titles for these workers and the duties that these workers perform. Indeed there are issues about training and education of these workers for the activities they perform and regulation of their work. At present there is no national regulation of support workers. Work currently being undertaken at De Montfort University (commissioned by the Department of Health) aims to establish the feasibility of regulation for this group of workers within health care.

Levels of competence and occupational standards

As in nursing, with the developing role of health care support workers and the use of National Vocational Qualifications, there can be value in the development and use of occupational standards and levels of competence.   The implementation of these provides qualified nurses with a basic level of confidence in delegating.

Generic working

There are few examples in the literature of a consideration of the accountability issues around generic support workers. Rolfe et al. (1999) describe a role developed to support the multidisciplinary team in delivering in-patient care. This role also raised questions of accountability.

"All staff identified concerns about who would be accountable for the generic worker, especially when the work they were doing was delegated from different professional groups. Problems were anticipated by the professional staff where a generic worker was implementing a therapeutic regime from one discipline, and there was no senior member of staff from that discipline available for supervision. Their key concern here was "who takes responsibility for that if something goes wrong", with the professionals appearing clear as to the limits of their own responsibilities and being unwilling to assume responsibility for issues which they saw as beyond their expertise. They were all worried that the lack of depth to generic worker training would give a false sense of security and lead staff to "have a go" without anticipating the possible consequences of their actions. The support

workers had similar concerns in terms of wanting the security of having someone available to consult and someone to whom they related in a line management capacity. None of the groups were convinced that these issues had been addressed, and identified the bottom line as being *the liability for actions taken by a worker who is not registered as a professional and therefore is not professionally accountable*" (p. 332)

Local Context

The action research study into the role of IPCCs has identified a number of issues around accountability which merit further debate within the directorate. On the whole, the IPCCs are understood to deliver a valuable service to patients and the interprofessional teams with which they work, and to date there are no known incidences of poor patient outcomes or complaints that can be directly attributable to IPCC practice. The IPCCs are monitored through weekly meetings held with their line manager (now the directorate Senior Nurse). Despite the lack of significant problems with the role, it is wise to consider 'worse-case scenarios' in order that patients continue to be protected in the face of, for example, changing personnel in the role of IPCC. So the point of the focus group is not to lay blame or claim that things aren't working at the moment, but to ask 'how can we continue to ensure that things go well?'

Key Issues *(taken from study data)*

The IPCCs vary as individuals in how they practice. Key examples include selecting patients for IPCC involvement and record-keeping. Practice may also vary according to individual workload and patient needs. The scope of practice on a day-to-day basis is determined by the IPCCs themselves.

Nursing recruitment problems and low attendance by nursing at multidisciplinary team meetings (because the meetings are organised around medical teams not wards) have meant the development of the IPCC role into discharge planning in areas where previously nurses would have had accountability. This may also be the case to a lesser degree with other work with other professional groups.

There is unclear accountability for the actions of the IPCCs carried out on behalf of or that inform the actions of nurses, doctors, therapists (working for another Trust), social workers (from a separate organisation) or other professionals and services with whom they work. Accompanying this is a lack

of systems for communication, reporting back, and monitoring of decisions made.

No training or development is in place for the IPCCs.

The concept of team accountability has not been clarified by the directorate

Questions for the Focus Group

Who is accountable for the IPCCs? Are there opportunities to clarify accountability?

Scope of practice: should there be outer limits set on what IPCCs can and can't do? Do the IPCCs have a discrete area of practice that is theirs and no-one else's? Within their current practice do the IPCCs 'exercise judgement which can substantially impact on patient health or welfare?' (J.M.Consulting, 1996)

Is there work the IPCCs now do that should be done by a professional group? (If so, what needs to happen to hand that work over to the professional group?)

What systems need to be put in place to ensure smooth interprofessional working and patient protection? - training and development, communication, documentation, monitoring.

Should we pursue professional status for the IPCCs?

Data Examples

Below are excerpts from two interview transcripts that help to highlight the issues for discussion:

Focus Group for Ward Managers, April 1999

N4   Communication is one issue but the other issue is that that who is responsible and delegation. There are some roles which should be nursing responsibilities that can be clearly delegated to the health care support workers rather than just left in no man's land well who is responsible and that should clearly be someone's responsibility that this takes place. Whether the nurse delegates it to the IPCC but maintains responsibility for it is what should be sorted out what roles are safe for nurses to delegate but should still be their responsibility so if anything happens it is the nurse's responsibility, do you know what I'm getting at?

N3   I think y'know the things like the social worker team referrals, we do them and then they take them and decide whether they should go through or not, and it's I was going to say well that's, I mean I haven't got a problem with them because the IPCCs know us and there is a good strong relationship here but taking those out, personalities y'know, it's sort of who's responsibility was it to go there cos as far as we are concerned, we have made the referral, they've deemed it not appropriate but, it's just an area of question, I just thought I'd throw that in

J   Yeah, I know that is interesting isn't it.

       Yes.

N6   So you are saying that they are vetting our work.

N3   Well that is what the system wants to do which quite rightly or wrongly y'know it was deemed that maybe there were inappropriate referrals. Now I would question whether that's more of a sort of, well the ward managers should keep an eye, and make sure whether the junior staff are actually making appropriate referrals, or whether it really needed to go on to the IPCCs to vet them who perhaps hadn't done the admission process or spoken to members of the family.

N4   So when they vet them, what do they do then?

N3   Well they decide whether they go through or not to the [social work] department

N4   But how do they decide?

N3   Just looking at what's made, or

N4   But would they bring it back to the senior nurse on the ward to discuss it.

N3   They usually take it back to the nurse who is on y'know in charge of that patient.

N4   So therefore the nurses still have the final vetting. If the nurses say 'no I think that should go' what would happen then?

N3   It would go but I'm not 100% sure that that actually happens.

N4   Well that is what I'm trying to work out is are because actually this is about delegation is that it shouldn't be their responsibility to decide what is or who or isn't referred but it is quite rightly come back to the senior nurse and then the nurse can look at it again but if they are vetting it without actually coming back and discussing it and being told whether it should go, if they are actually the ones who are saying it should go or not go then they are vetting affecting our work *(13049n, pp.11-12)*

Interview with social worker November 1998

If there were enough nurses, or doctors and Social Workers, there wouldn't be a role for the IPCC. Sometimes I get the feeling that it's the IPCC role to chase us up, to police our role. They don't have the authority to do that. They don't come from professional backgrounds....The Social Worker is legally vulnerable. The Social Worker is responsible for patients 3 weeks after discharge, even if they have not been involved with them as an in-patient. ...[The IPCCs] don't have a professional framework. As a Social Worker you are trained to do assessments. You know what you're assessing for; you're applying theories to establish a rapport with the patient and to assess for needs.   If you are communicating with vulnerable people you need communication skills. You need to know why you are doing what you are doing. You need to understand your role, the boundaries of your role, to put purpose to your work, to back it up with a body of knowledge. *(12118sw2, pp.1-2)*

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Jackie Bridges
Karen Spilsbury

Appendix 8: Briefing note for workshop 2

<u>**Workshop on Interprofessional Working**</u>

Thursday 8th June 2.30-5.30 p.m. in *(location and directions)*. If you cannot come, please send a representative. If this is not possible, let Jackie know on *(telephone number)*.

Introduction

This workshop is taking place as part of a wider action research study in the Medical and Emergency Directorate (MED). While the study has focused mainly on the role of the directorate's Interprofessional Care Co-ordinators, data gathered have also thrown light on wider issues of interprofessional working. This workshop is being held to:

   Share data from this study (and the study within the directorate on the Transmission of Patient-Based Information) on interprofessional working, and to consider the patient perspective on interprofessional working.

   Learn from the literature and external visitors about work going on elsewhere to improve the effectiveness of interprofessional working.

   Enable people working in MED to identify the key issues in interprofessional working in practice, and to draft an action plan for these issues (if this is needed).

We would like to tape-record the workshop proceedings for use as study data. Any information gathered in this way will be treated in confidence and will be anonymised prior to any wider distribution (for example, discussion documents and publications) so that participants of the workshop can remain anonymous. Please let us know in advance if you have any problems with this or if you have any queries.

Thank you very much for taking part.

Advance Work for MED Participants

For those participants working in MED:
Read the information in this briefing note and discuss it in advance with your colleagues. Come to the workshop prepared to represent the views of your professional group on the following:

   What does and doesn't work well in interprofessional working in MED?

   What would you like to know from the external visitors to the workshop?

   Where things aren't working well in MED, what are realistic solutions?

   What needs to happen to put these solutions in place, and what can <u>you</u> do to contribute?

Also, for MED participants only: please come to a follow-up session on Wednesday 21st June, 2.15-3.45 p.m. in the *(location)*.

External Visitors

People working at the Trust may want to discuss openly with you some of the issues they are working with. While it is unlikely that the existence of these issues is unusual compared to other hospitals, please respect the need for confidentiality, and do not share information outside of the workshop that could be misused or misunderstood by other parties.

Please contact Jackie Bridges on (telephone number) or Julienne Meyer on (telephone number) with any queries.

Participants

People working within Medical and Emergency Directorate (MED)

Nursing: *(names of invitees)*

Medicine: *(names of invitees)*

OT: *(names of invitees)*

Physiotherapy: *(names of invitees)*

Therapies: Trust Director of Therapy Services

Care Co-ordinators: *(names of invitees)*

Fast Response Team: *(names of invitees)*

Pharmacy: *(names of invitees)*

Social Work: *(names of invitees)*

People working at the Trust in other directorates

It is hoped to get representatives from Infection and Immunity, and from Trauma and Orthopaedics to share their models of interprofessional working - this has yet to be confirmed.

External People *(see later for rationale)*

Community Health Council Officer

Head of Quality, *X* NHS Trust

Senior Research Fellow, *X* University

Project Co-ordinator, Team-Based Learning, *X* Education Consortium

Researcher, City University

 (Care of the Elderly at *the local community Trust* will be sending a written summary of their models of working.)

Researchers/Facilitators of Workshop (all from St Bartholomew School of Nursing & Midwifery, City University, London)

Jackie Bridges
Prof. Julienne Meyer
Jane Bentley
Dr Aruna Sanikop
Alex Atibioke

Action Research Study on Co-ordination of Interprofessional Care
Summary of Literature Reviewed

There is an enormous body of literature related to interprofessional working in health care, and the research team is currently working its way through it! Broad findings to date are:

there does appear to be an association between interprofessional working and good patient outcomes.
there are a number of factors which are often associated with 'good' interprofessional working: agreed team aims, clear lines of managerial and professional accountability, understanding of each other's roles and responsibilities, good communication mechanisms, investment in team training and evaluation activities
other influencing factors can be power issues particularly in relation to profession and gender; organisational context

Some extracts from the literature are included in this pack as they provide specific examples which may be of help to the directorate in considering a way forward.

Summary of Relevant Data from Action Research Study

Composition of Interprofessional Team(s)
Interprofessional relationships are generally good in MED and there is a commitment from staff involved in the study to date to interprofessional working. A number of factors mean that there is no one stable interprofessional team:

The range of professionals involved in a patient's care varies according to that patient's needs, and some professions are more usually involved than others.

Professions vary as to whether they organise their work/which patients they become involved with - some are organised by ward base and some by consultant team.

There is also a turnover of staff, most notably junior medical staff who move on every three months.

Communication between Professionals
There are four means of communication between interprofessional team members:

Written
Telephone
Meetings
Other face-to-face informal

Written communication takes place in the individual profession's own files. Medical and nursing notes are ward-based and available for others to consult and to write in. Much of the communication in relation to patients is opportunistic, verbal and informal (either on telephone or face-to-face outside of meetings), only a proportion of it being subsequently written down. Some wards have set up multidisciplinary communication sheets. A number of individuals have suggested developing multidisciplinary documentation.

Meetings can take a number of forms: ward rounds; weekly multidisciplinary team meetings, case conferences. There is a tension as to how frequently nursing staff attend medical ward rounds.

Weekly multidisciplinary meetings are held around the medical teams rather than the ward bases. Regular attenders at these meetings are IPCCs, OTs, Social Workers, Respiratory Physiotherapists and Doctors. Neurological Physiotherapists attend five (out of eight) meetings often (the others are attended never or rarely), and Nurses attend four meetings regularly or often (the others are attended rarely). Pharmacists, speech therapists, patients, support workers and community staff never attend. The meetings are mainly focused on discharge planning and 'moving people through' their hospital admission. Individual meetings vary in style, and this is to some extent dependent on the seniority of medical staff who attend. Because nurses find it more difficult to leave their ward base, and it is harder for nurses to cover patients at meetings from other wards, some nurses feel that the way that meetings are currently organised excludes an important nursing contribution.

Generally the systems used for interprofessional working are historically based and rarely reviewed. The flexibility needed for individual patients' needs has led to a degree of informality as to who is involved in decisions taken and in what way. Given the pace at which decisions are taken and the difficulties involved with communicating with all relevant people all the time, there is a constant potential for a key professional 'not knowing' what is happening for a patient. Reviewing the use of written records and formal meetings, and/or formalising the informal systems may help reduce this potential.

External Visitors and their Potential Contributions

Senior Research Fellow, *X University*

X has been running a research study in MED looking at the transmission of patient-based information within the multidisciplinary team. *X* has been invited to share the findings of the work to date to contribute towards discussion at the workshop.

Officer, Community Health Council

X has been invited to enable people working in the directorate to further consider the patient perspective in planning changes to interprofessional working. *X* has been invited to investigate with colleagues at the CHC and report back on the following:

Respecting patients' values and needs: to what extent are patients and families involved in decisions about their treatment and discharge, and is there scope for improvement? What is the quality of information that patients get and how well is it communicated?

Co-ordination and integration of care: Is it clear to patients who is in charge of their care? Do different professionals communicate well with each other or do they contradict each other/appear uninformed? Do patients/families get asked the same questions by different staff without explanation? How well do staff and services seem to be co-ordinated?

Head of Quality, *X* NHS Trust

X Hospital is well known for its pioneering work in process management from a patient-focused perspective, including the development of managed care by multidisciplinary protocols and multi-skilling. *X* oversees the work taking place and has been invited to share what is going on.

<u>Project Co-ordinator, Team-Based Learning, *X* Education Consortium</u>

X Education Consortium has funded a two year project on team-based learning, of which *X* is the co-ordinator. In the project, six different multiprofessional teams have been facilitated over time to use scenarios based on case studies to improve their team-working. The modules covered have included:

> What is a team?
> Leadership/Power
> Communication
> Integrated processes
> Role awareness

While the Consortium does not plan to make the learning material available more widely yet, *X* has been invited to share her thoughts on the project to inform the thinking as to what may be useful ways of improving effectiveness, and to consider whether investing in team development activities may be helpful.

<u>Scott Reeves, Researcher, City University</u>

Scott carried out the pilot work on the IPCC study, and since then has been involved in evaluating an interprofessional training ward and conducting a systematic review of literature on interprofessional education. He has been invited to contribute to discussions at the workshop.

Jackie Bridges
(contact details)

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