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Towards a Conceptual Framework for Interprofessional Practice in the field of Learning Disability

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ABSTRACT

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Several decades of policy and service change in the field of learning disability have brought about the creation of a new set of service boundaries in health and social care. These boundaries focussing on service funding, resource management and care provision, have led to new working relationships for professionals based on interprofessional collaboration. This changing context of practice has clarified the responsibilities of social work agencies and primary health care teams, whilst reaffirming the learning disability nursing role, which is based on meeting the complex health care needs of people with learning disability in the community.

Despite clarity in policy, economic pressures may result in agencies offering resource led rather than needs led services. This can lead to tensions between professional groups who are faced with tough choices in order to meet the long term need of people with learning disability and their families. Whilst social workers and learning disability nurses hold key roles in ensuring these needs are a priority, in order for them to do so, a critical understanding of the context of practice, interprofessional roles and relationships and teamwork is required. Further, since the nineteen sixties, numerous policy documents have exhorted collaboration and interprofessional practice in health and social care, with little in the way of guidance until very recently.

As a practitioner in the field, I felt that a greater understanding of how practitioners worked interprofessionally was needed, and this desire was to be the starting point for my research. This thesis records my journey in a research study which explores the interprofessional practice experience of learning disability practitioners. Starting from my original broad research question "How do professionals in the field of learning disability view interprofessional practice?", the thesis explores the context of learning disability practice and the impact of history on present day services. Set within a general grounded theory methodology it documents my relationship and interactions with the research participants. Choices in relation to methodological decisions made are charted, whilst the dialogue with participants is presented from two analytical perspectives.

Firstly, a descriptive analysis of the individuals experience of interprofessional practice. This introduces key roles of the practitioner and identifies significant practice based knowledge. The impact of these roles and knowledge are explored in relation to professional and interprofessional confidence, teamwork strategy and subsequent use of power of the participants.

Secondly, an analysis of critical elements of participants personal knowledge, is used to construct, through concept analysis, a preliminary theoretical framework. Thus presenting the components of a model for interprofessional practice in the field of learning disabilities.

Towards the end of the journey, the frameworks' application in practice and its contribution to the field are presented, highlighting the knowledge gained and affirming the contribution of practitioners. The framework's effectiveness is considered in relation to operationalisation, congruence in a changing practice context, standards of professional practice and empowerment.

Finally, the framework's contribution to knowledge is assessed and future research suggested: as this journey ends and another begins.

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Use of Terminology

Use of language

I have used the term Learning Disability because of its use in the United Kingdom national policy context. Gates (1997, p. 8) offers the following definition of Learning Disability which is used to describe " a group of people with significant developmental delay that results in arrested or incomplete achievement of the 'normal' milestones of human development. These milestones relate to intellectual, emotional, spiritual and social aspects of development". When there are significant delays in one or more of these areas, a person may be described, defined or categorised as having a learning disability, the causes of which are multifactorial.
Other definitions such as idiot, feebleminded and mental handicap are used in their historical context, whilst recognising their devaluing nature in contemporary writing and practice.
In some literature the label "Learning Difficulties" is used in place of Learning Disability. Where this is the case, the term has not been changed but remains as in the original text.

The term interprofessional has a range of meanings within the literature and is explored in chapters two, four and seven of this thesis. The meaning of interprofessional used by myself is derived from Leathard (1994, p. 5)and can be defined as a number of professionals, carers and service users working together, in a range of team work situations and settings. A range of other terms is used interchangeably in the literature, most commonly multidisciplinary, multiprofessional and multi-agency.

Multiprofessional implies several different groups working together. However as Payne (2000, p.9) notes, this may not mean that professionals will adapt their role. Emphasis is on collaboration not crossing professional boundaries.

Multidisciplinary has been used in the literature, to explore or describe knowledge and skills of professionals, and their contribution to team work.

Multi-Agency describes work that may cross structures in organisations and in services (Payne, 2000, p. 9).

Abbreviated Terms

CCETSW	Central Council For Education and Training in Social Work
CMHT	Community Mental Handicap Team
CNLD	Community Nurse Learning Disability
DipSW	Diploma in Social Work
DOH	Great Britain, Department of Health
EN	Enrolled Nurse
ENB	English National Board for Nursing, Midwifery and Health Visiting
GNC	General Nursing Council
IPP	Individual Programme Plan
MPA	The Medico-Psychological Association
NHSE	National Health Service Executive
NMC	The Nursing and Midwifery Council
PASS	Program Analysis of Service Systems
PASSING	Analysis of Service Systems ' Implementation of Organisational Goals.
RNMH	Registered Nurse Mental Handicap
RNM	Registered Nurse Mental Illness
RN	Registered Nurse (Acute Nursing)
RNLD	Registered Nurse Learning Disability (Part 14 of the NMC Professional Register).
SSI	Social Services Inspectorate
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Chapter One

Introduction to the Research Journey

This chapter provides an overview of this study "Towards a Conceptual Framework for Interprofessional Practice in the field of Learning Disability". In this chapter the research area and the researcher are introduced. This is followed by a brief description of the chapter structures within the thesis. These set out the stages on the research journey and my role as researcher. My interactions with the research participants and their influence are highlighted until I finally arrive at the journeys destination, the development of the conceptual framework itself.

1.1 The Starting Point

1.1.1 My experience and its influence on the study

As a practitioner in the learning disability field for more than twenty years, one of my major concerns was the lack of substantive, formal or practice theory to draw upon in relation to interprofessional practice, despite this being a core element of service user support. My aim therefore was to further explore practice in this arena. My research question was a broad one based on a desire to articulate practitioner thinking on practice action in the field :- .

" How do professionals in the field of learning disability view interprofessional practice?"

I felt a pressing need to examine more closely the realities of practice, placing them under scrutiny and capturing solutions to barriers in the interprofessional context. I sought to do this by exploring the views of other practitioners in the field in the form of a dialogue about practice.

1.1.2 The research participants

All of the participants in the study were working in the long term support of people with learning disability. A series of processes identified the core group of participants and these are presented in chapters five and six. A decision was made by the researcher to define key professionals in the long term support of people with learning disability as social workers and nurses holding the

Registered Nurse in Learning Disability (RNLD) qualification. I acknowledge the input of other professionals in both long and short term support of this group of people, and indeed the major role of vocationally trained workers in health and social care. The focus on social workers and nurses in this study reflects their predominance within the local work force in offering long term support for this group of people.

At the beginning of the study both social workers and nurses were research participants. This changed as the research progressed in the second part of the study, based on the emerging data analysis (See chapter five). One result being the participation of a core group of participants who held the RNLD or the RNLD and Diploma in Social Work, (DipSW) qualification and all of whom were employed as RNLDs.

1.2 The Guiding Principles of the Research

At the start of the journey I had identified a broad research question and my intention was to see what emerged on the journey ahead. I had no fixed hypothesis and my practice values were influential in the choice of a qualitative approach to research. The research strategy was founded on the use of general principles of grounded theory methodology which have enabled:

- The researcher's experience of the practice context to be an explicit element of the research process
- A dialogue between the researcher and the research participants to inform the research process
- Real world experiences of practice to inform the research process and stages.
- A detailed exploration of the context of practice, drawing on practitioner accounts and understandings
- A flexible approach to the collection and analysis of data developed from the researchers engagement with the data on the research journey (Mason, 1996, p. 4)
- The researcher to be flexible in the exploration of contradictory and confirming data
- The researcher's interaction with the data to be carried out in a critically reflective way

- The position of the researcher in response to ethical issues and power relationships to be made explicit in the methodology.

1.3 Outline of the thesis

Chapter Two: Contextual Issues in Interprofessional Practice

This chapter marks the start of the research journey. It sets the scene for the study offering a general introduction to policy directives influencing interprofessional practice since the establishment of the National Health Service. It is underpinned by a description of the broad historical development of health and social care and the evolvement of interprofessional working. The chapter begins with a description of organisational structures and their impact on collaboration, legislation and policy development. Government initiatives and educational strategies, are examined. The role of professionals operating within health and care frameworks is debated, and the tensions of professional boundaries are introduced. Practice focussed interprofessional working is explored, in the form of complex interactions between professionals and other professionals, and professionals and people who access services.

Chapter Three: Learning Disability and the Context of practice

This chapter looks specifically at the field of learning disability where there have been substantial calls for collaboration and interprofessional working. The position of people with learning disability, and the professional groups that support them, will be considered with specific reference to long term support and in the broader context of historical policy development and service delivery.

A number of conflicting and contested claims for professional domination are presented, set against a backdrop of minimal service budgets. The ideology of normalisation and its influence on a policy agenda centred increasingly on user rights, physical and social integration is acknowledged, amidst the tensions of resource allocation. Also explored are the historical differences between the medical and social models of practice, with emphasis on the role of the nurse. Highlighting the continuing marginalisation and oppression of people with learning disability, the chapter questions the values of public and professional alike.

Chapter Four: *Teamwork in Practice*

This chapter builds on the broad historical and contemporary review of health and social care policy, and its influence on interprofessional collaboration discussed in chapter two, and the attention focussed on people with learning disability and the key professional groups that offer longer term support, in chapter three. Here, an analysis of research into interprofessional teamwork and learning disability practice is presented. By outlining some of the complexities, contradictions and limitations of research undertaken, the researcher suggests that through positioning the individual's practice action within a narrow organisational context of teamwork practice, critical factors related to the structural and holistic frameworks of learning disabilities care provision may be excluded. Consequently such approaches may have hindered the development of any specific theories for practice in the learning disability field.

Chapter Five: *Key Elements in the Research Process*

Chapter five explores the first stages of the field work part of the research. On route to achieving this I had to work through a series of personal barriers about the nature of research and the role of the researcher, before any progress could be made. Additionally I was still making sense of the context of practise and its impact on my role as a practitioner in the field of learning disability. The use of the general principles of grounded theory methodology have facilitated this process and these are explored through out the chapter. Factors underpinning the researcher's action are developed in an account of the application and analysis of a semi-structured questionnaire, undertaken in preparation for a series of topic focussed interviews, forming the next part of the research

Chapter Six: *"Its Just Stuff on a Grand Scale"*

Here I reflect on decisions made in preparation for the topic focussed interviews, and the nature of relationships between myself and the research participants. The interview process itself is discussed within an account of the strategies adopted to achieve a dialogue with participants and focus on the research themes. From these interviews a first level analysis of data is presented. The resulting picture offers a description of the individuals experience of interprofessional practice, introducing key roles for the practitioner and impacting on the teamwork strategy and subsequent empowerment of participants.

Chapter Seven: *The Conceptual Framework*

This chapter further analyses the critical elements of participant's personal theory developed in chapter six, which involved representing personal theory in the form of practice characteristics. These characteristics are then examined through the process of concept analysis, wherein identified concepts are scrutinised and defined for use in the construction of a conceptual framework. The concepts which form the content of the framework, offer the evolutionary components of a model of interprofessional practice, to be used in the long term support of people with learning disabilities. Throughout the development of the framework, the nature and generation of empowering practice is explored.

Chapter Eight: *The Framework in Practice*

Chapter seven has outlined the development of a conceptual model generated to provide practitioners with a framework for intervention in the interprofessional practice setting. The framework has been designed to be used in both everyday and crisis situations, with emphasis on individual practitioner intervention. Whilst the long term applicability of the tool has yet to be tested, the chapter considers the frameworks' potential uses, further development and broader application.

Chapter Nine: *Concluding This Stage of the Journey*

In this concluding chapter I will reflect on the personal experience of developing the framework so far and its contribution to the field of learning disability practice. In charting the processes involved, the chapter will return to the original research question "How do professionals in the field of learning disability view interprofessional practice?" and the end result, the development of a provisional conceptual framework for interprofessional practice. The contribution to the field will be documented and the innovative nature of the research endorsed. These conclusions will mark the end of this part of my research journey and set the scene for the next.

Chapter Two

Contextual Issues in Interprofessional Practice

Interprofessional practice underpinned by collaboration has been a key aim of policy directives since the establishment of the National Health Service. This chapter describes the broad historical development of health and social care and the evolvement of interprofessional working. Beginning with organisational structures and their impact on collaboration, legislation, policy development, government initiatives, and educational strategies, are examined. The role of professionals operating within health and care frameworks is debated, and the tensions of professional boundaries are introduced. Practice focussed interprofessional working is explored, in the form of complex interactions between professionals and other professionals, and professionals and people who access services.

2.1 Historical developments : Post War Professional Practice

2.1.1 Moves toward a definition of Interprofessional Practice

The post war organisational restructuring of the health and social care departments, have set in place complex arrangements for professionals attempting to work interprofessionally. A series of successive governments have stressed the need for improved interprofessional working, whilst the route toward achieving this has not been straight forward.

Throughout this period, a number of terms have been used to describe the process itself. Pietroni (1994, p.77) observes that interprofessional means different things to different people, whilst different professionals speak different languages that influence both their mode of thought and identity (Pietroni,1994, p.70). Historically in health care, the terms "multi-disciplinary" or "inter-disciplinary" are used to describe "a team of individuals with different training backgrounds, who share common objectives but who make a different but complementary contribution" (Marshall et al, 1979 cited in Leathard, 1994 p.7). The application of "inter" may be viewed by some, as practice between only two professions or professionals, hence the use of multi- disciplinary or multi- professional (Leathard, 1994, p.6). However Payne (2000, p. 9) suggests that 'inter' may be used to describe a blurring of professional roles or cross professional boundary working. More recently the term multi-professional has been replaced,

or used interchangeably with the term inter-agency working. Inevitably ambiguity surrounds both the meaning and application of language, and the processes described.

2.1.2 Historical Structures and practice

National health service and social service reforms in the 1960 's and 1970 's attempted to redress the segregation created by the operational structures of some professional groups. Carrier and Kendall (1995, p.16) draw attention to the isolation of General Practitioners (GPs) working in separate practices with local authorities employing domiciliary midwives, district nurses and health visitors. The Doctor's charter (1966) brought about the establishment of group practices (Carrier and Kendall,1995, p.16) and the Health services and Public Health Act of 1968, created the structures required for the cross boundary working of community based nursing staff. Whilst these changes underpinned the primary health care team, it was recognised that for effective community care, other agencies in social services needed to be involved. One solution was the integration of the NHS within local government. This would alleviate concerns about public spending and use of resources.

In the event this was not to occur. Hugman (1995, p. 33) reflects on the impact of earlier legislation, whereby the National Health Act (1946) and the National Assistance Act (1948) set in place parallel welfare state organisations. These "first generation" organisations, provided the framework for subsequent "second generation" organisations and the resulting boundaries for professionals in health and social care. Hugman (1995, p.33) gives an example from residential care. As responsibility for adults in need fell with local authorities in part 111 of the National Assistance Act, then former Poor Law facilities became geriatric hospitals as part of the NHS. Although both were the responsibility of doctors, Hugman (1995, p.33) notes that local authority care was from the outset perceived as social care. Thus in both the popular and professional conscious this was to be the case (Hugman, 1995, p.33), creating the existing divide.

2.2 Barriers to Integration

For Carrier and Kendall (1995, p.16) the medical profession's reluctance to be under local authority control was crucial in the lack of progress toward integration. Since the inception of the NHS in 1948 GP's have been fighting to maintain their independence (Baggott ,1998, p.94). Equally as King (1975, p.285) records, administrative changes in the 1960 's and 70 's

had cost the government a good deal with limited results. The threat of inflation and an out of control economy may also have prevented more radical shift in organisation.

A diminished move toward integration in the NHS occurred in 1974, following the re-organisation of the NHS in 1973. Joint consultative committees were established to co-ordinate the use of resources and to take account of policy integration (Loxley, 1997, p.95). General practice, hospital based and community services were brought together under one administrative structure to become health authorities. Family practitioner services still remained separate, with family practitioner committees supporting the services of GPs dentists, pharmacists and opticians. Local government was responsible for social care. At this point in time, health authority and local authority boundaries were co-terminus (Land ,1991, p.206). As a result of the act, other changes were also to happen in social care. In 1970 following the Seebohm report (1968) social service departments were created. The practice of social workers moved away from a specialist role, to that of a generic worker, equipped to support all families and children in the community.

The issue of integration remained on the agenda. As a result of the 1976 guidelines, joint care planning teams were established. The purpose of these was to encourage strategic rather than operational planning (Loxley,1997, p.96). To endorse collaboration, joint finance guidelines as part of the joint finance scheme were also introduced. From this point further moves toward integration were dismissed. The outcome of a Royal Commission established in 1976 was to decide against the possibility of integration stating that it was not required for better collaboration (Royal Commission on the NHS, 1978). Strong support for interprofessional practice was offered, although with the acknowledgement that the removal of institutional barriers might not in themselves create collaboration. This belief was labelled the "organisational fallacy" (Carrier and Kendall ,1995, p.18).Equally the belief that conflicts of objectives would be resolved through bringing everyone together in one system, was labelled the "unitary fallacy" (Royal Commission on the NHS, 1978 p. 223-232).

2.3 The Health and Social Care Divide

Since the mid 1970s a number of reports have focussed on the health and social care divide. The document "Patients First" (DHSS,1979) was an attempt to redress the complexities of separate organisational funding. Joint commissioning of projects across health and social care were to be supported, with the establishment of joint care planning teams. Even though these

were to remain on a small scale with few success stories reported (Ham 1992, Chapman et al, 1995).

At the start of the 1980s the Conservative government brought about more organisational change in health and social care. The Harding report (DHSS,1981a) was to encourage greater teamwork in primary care. The Griffiths report (DHSS,1988) and it's recommendations founded upon general management principles, noted a lack of responsiveness to client or patients needs from professionals. One of the findings of Griffiths was the lack of supporting structures for collaboration. To address this social services were to be the lead agency for community care (Loxley, 1997, p.18). A managerialist approach based on business principles was to shake up the position of some professional groups, in particular nursing (Cox, 1991, p.101). In addition, Griffiths recommended the development of a new form of generic worker, who could work across service boundaries and deliver a seamless service to clients and patients.

Throughout the nineteen eighties, a number of organisations were developed to support interprofessional training and education for practice. Building on alliances between CCETSW , the Council for Training in Health Visiting(CTHV) and the Royal College of General Practitioners (RCGP) in the nineteen seventies, these included in 1987 the European Network for Multiprofessional Education, and the Centre for the Advancement of Interprofessional Education (CAIPE), in 1984 which was to form the UK network.. Additionally the Centre for Interprofessional studies in Nottingham and the Royal College of General Practitioners' Primary Care Alliance were established in 1989 and 1993 respectively.(Spratley and Pietroni 1996, p. 254), along with the Commission for Primary Care in 1993.

The rise of CAIPE in becoming a major force for the promotion of interprofessional research, the development of data banks and in seeking the support of professional associations is noted by Loxley (1997, p.66) Further as Loxley notes (1997, p.67) tensions similar to those in practice were to challenge interprofessional organisations where funding and the setting of priorities for research created a number of conflicts.

Nevertheless whilst progress had been slow in terms of collaboration when the three earlier bodies had set out in the nineteen seventies, as Loxley (1997, p. 65) writes, the nineteen eighties saw a shift in 'gear'. Within educational institutions, the results of a study by CAIPE undertaken between 1987 and 1988 identified 695 joint training programmes offering educational events of half a day or more (CAIPE 1989). Whilst a study by Storrie (1992)

highlighted fifteen higher education establishments offering Masters level programmes with a focus on interprofessional working. Leathard (1994, p. 30) charts the development of three key programmes. Firstly the University of Exeter's Masters in Interprofessional Practice established in 1986 as a response to the geographical location of practitioners and its perceived impact on the delivery of interprofessional practice (Goble, 1991). Secondly the University of the South Banks' Masters in Interprofessional Health and Welfare studies in 1990 and finally the Marleybone Centre Trusts' Masters in 'Community and Primary Health Care' in 1993. These educational initiatives were viewed as a response to the government document "Working Together" (DOH, 1991) centred upon individual professional decision making and agency policy at local level (Spratley and Pietroni, 1996, p . 255).

Other reports and papers were also to have an effect on practice. Loxley (1997, p.18) draws attention to the Cumberledge report (DHSS, 1986a) on neighbourhood nursing and the green paper on primary care (DHSS, 1986b). Key components of which were the emphasis on team working and a more effective use of resources. Within primary care the government whilst not backing the Cumberledge report in totality, mapped out its own views on primary care in the white paper Promoting Better Health (DHSS,1987) .

Both "Working for Patients "(DHSS, 1989a) and "Caring for Patients" (DHSS, 1989b) and the introduction of the family doctors' contract, which provided payment for health promoting activities offered in the GP practice, radically reformed both professional practice and the delivery of health and social care. The introduction of the internal market was to transfer the focus of practice to an outcome driven purchaser/ provider split system. GPs could purchase their own primary health care team support. In social care emphasis was centred upon care in the community, whilst the provision of care was increasingly to be provided by support workers. Care packages were to be designed and resourced through a care manager. The mental health circular HC(90) 23 mapped out guidelines for the care programme approach (Corney, 1995). A significant change in the role and remit of the voluntary and independent sectors also took place. No longer was their role to be largely that of provider of additional services. In contrast they were to become involved in the delivery of essential elements of care provision.

Within primary care the commitment to effective team working was challenged with the Audit Commission document "Homeward Bound" (Audit Commission , 1992), and endorsed through the document "New world. New Opportunities" (National Health Service Management Executive, 1993). The advent of GP fundholders who were involved in purchasing services

created more organisational change, one outcome being a further move toward the separation of services .

As Loxley (1997, p.19) indicates, the means to achieve collaboration are set out in policy documents. Within these documents, there appears to be confusion over goals and values. Equally there are conflicting aims and functions for agencies. In terms of collaboration, agencies are attempting to meet local need, yet are operating amongst the financial constraints of central government. Funding issues have been one of the mechanisms for the division of services and roles and the emergent health and social care divide (Beardshaw and Morgan ,1990).

The Labour government which came to power in 1997 has already introduced further organisational reforms. Within the White paper the "New NHS, Modern, Dependable" (DOH,1997), the role of the GP fundholder in primary care has been dismantled, whilst the planning and commissioning of health care will be part of the remit of Primary Care Groups (PCGs),and Primary Care Trusts (PCTs). Williams and Laungani (1999, p.28) describe the main function of PCGs, as contributing to the local health information profile, promoting the health of local populations, monitoring the performance of providers of commissioned care whist working across practices and integrating the work of primary care with social services.

The role of health care trusts has changed, as PCGs and PCTs become established. A major review of social care focussed on the White paper "Modernising Social Services" is ongoing (DOH, 1999). Changes implemented by the Labour government, present the opportunity for structural changes to support collaboration. " Partnership in Action" (HMSO, 1998) sets out key areas for working together, between health and social services. The directive "Modernising Health and Social Services, National Priorities Guidance 1999/ 00- 2001/02 (HMSO, 1999) provided a framework for the transfer of funds, and the delegation of the commissioning function and the integration of health and social care (Campbell and Proctor, 1999, p.851). In addition planning guidelines for Primary care groups (NHSE, 1999) indicate size and population criteria which could work with coterminous boundaries of local or unitary authorities. At present it is too early to evaluate the impact at a national level, although some major evaluative studies are ongoing (Kings Fund , 2000).

2.4 Policy Development

It is interesting to contrast the more formal development of policy in the field of child protection to that of learning disability. In the field of child protection, the Report of the Committee of

Enquiry into the Care and supervision provided in relation to Maria Colwell (1974), and the Report of the Tonbridge Wells Study Group (1973) stressed the need for a more formalised approach to the support of children at risk, having identified key areas of failure across the professions. A lack of co-ordination between education, social services, housing and the police was noted. Overall the report drew attention to inefficient procedures in the systems of communication, administration, planning, liaison and supervision. All of which occurred in a situation where family relationships were complex and difficult.

As a response to the enquiry findings, a legislative framework within which organisations must work interprofessionally was implemented. Birchall (1995, p. 112) draws attention to the application of mandatory coordination within child protection (Hauf, 1978), whereby an external more significant force is needed to ensure that agencies co-operate when there may seem to be limited shared areas of interest and a lack of differentials of power which may prevent the achievement of good working relationships.

Further developments occurred as a result of the Court Report (DOH,1976), which established multi-disciplinary teams and the beginnings of integrated child health services. The Jasmine Beckford inquiry (Blom-Cooper, 1985) again emphasised the importance of communication across professional groups and agencies. Whilst after the findings of the Cleveland Inquiry, (Butler-Sloss, 1988) were made public, an attempt to bring about real change was made (Biggs, 1997, p.190). The report "Working Together under the Children Act 1989" (DOH, 1991), clarified the arrangements for inter-agency working across the professions. Interprofessional working must be demonstrable, as the Children Act indicates (DOH,1989 c). The care and protection of children is becoming increasingly legalised, (Biggs, 1997, p.190) and in terms of interprofessional practice forms a key element of criminal justice work. Further as Birchall (1995, p.114) notes, this far exceeds the mechanisms in place for other vulnerable groups of people.

The field of learning disability has been an area in which substantial calls for collaboration and mult-professional working have been made. In 1971 the publication of the report " Better Services for the Mentally Handicapped" was to question service delivery and it's appropriateness. As in the Maria Colwell case, Better Services was published in the aftermath of an enquiry, this time into conditions for people with learning disability living in Ely hospital (DHSS, 1969). The National Development team which contributed to the Better Services document addressed the very nature of care and it's relevance to this group of people. Unlike

the arena of child protection operating within a legislative framework, calls for improved interprofessional working were focussed on the need for improved practice and were reliant on the commitment of professionals to create change.

"Caring for People" (DOH,1989) was to place responsibility for the management of care of people with learning disabilities within the remit of social services. Whilst since its implementation there has been a questioning of both the service models available and the educational and professional preparation of those workers in the field. Recently "Valuing People" (DOH, 2001) the new white paper for people with learning disability, has further emphasised the need for joint working and joint assessment in the provision of quality services.

2.5 Interprofessional Working and Community Care

The fields of learning disability and mental health along with services for elderly people, were to be transformed with the implementation of community care. Care in Action (DHSS, 1981b) and Care in the Community (DHSS, 1981c) brought the message of collaboration to the fore. Health Authorities and Social Services were set to work together in the identification of priority services and groups and in the sharing of resources (Loxley, 1997, p.97). In 1985 the second report from the social services committee on community care set in place joint planning mechanisms. These were to be stressed throughout the 1980's. Progress in Partnership (1986) a joint report from the Local Authority Association and the National Association of Health Authorities, also worked toward a mutual goal of avoiding gaps in service (Loxley, 1997, p .99), and the need to improve the use of resources. In the 1980s several community care projects took place and were evaluated. In learning disabilities the case management project in Kent worked across agency boundary divides (Challis and Davies, 1986). Good practice is documented (Chapman, 1995, p.49) although the local or small scale nature of success is referred to. The result of allocating separate resources for vulnerable groups of people may lead to a lack of access to other services. This is well documented in the field of learning disability, when primary care provision is evaluated (Stein ,1996 p .8). In mental health gaps in service for the long term person with mental illness are noted (Corney, 1995, p.148). Equally the rationale for endorsing interprofessional practice as a means of addressing such gaps in service may be viewed as contentious (Loxley, 1997, p.45).

Addressing such service tensions, the Audit Commission (1986) reported a series of missed opportunities for collaboration, with Chapman (1995, p.46) suggesting that rate capping

was a disincentive for local authorities to put funding into joint initiatives.

2.6 Present Day Policy and Interprofessional practice

A series of events in the 1980s, placed interprofessionalism in the centre of the debate around professional roles, particularly in community care. The Griffiths' report (1988) supported the development of a new form of ancillary or generic worker. This move toward genericism would have removed the need for the focus on interprofessional practice. Professionals would continue to work within their own boundaries, whilst the generic worker would provide "hands on" care across the divide of health and social care. Leathard (1994, p.9) writes that the pressure to "go interprofessional", speeded up in the 1980s and '90s under the impact of government policy.

At the time of Griffiths, individual professions were increasingly being threatened by the rise of a new managerialism, which set in place a management structure separate from the consensual, corporate decision making system which typified the NHS. This new managerialist approach was seen to be an effective mechanism for quality service delivery. Within the managerialist framework, professionals were either purchasers, involved in competitive tendering, or on the provider end in the delivery of services (Cohen, 1995). The impact of such splits, resulting in a lessening of professional allegiances.

Since the 1990s, emphasis has focussed upon joint planning, co-ordination and community care plans, hospital discharge policy, joint purchasing through consortia, and mergers (Leathard , 1994 p. 9).There has been a shift from a market driven arena for care, to that of public and private partnerships within the NHS and with other partners such as local authorities. Section 31 of the Health Act (1999) sets out arrangements for partnership working (DOH, 1998).These developments place emphasis on inclusion for all, as part of the current Labour government's modernisation agenda within the NHS plan (DOH, 2000) resulting in the emergence of a new set of challenges for professionals. Further reform of workforce planning within the NHS is also ongoing, in response to the consultation document 'A Health Service of all the talents : developing the NHS workforce' (DOH, 2000).

The development of primary care groups with responsibility for public health planning and commissioning of health services may provide the opportunity for re-negotiation of roles across professional boundaries (DOH, 1997). Equally the emphasis on "Best Value" in local government (DHSS, 1998) and a developing clarity in terms of social care re-enforce the need

for collaboration, set within new organisational structures. Draft guidelines for practice in partnership working are currently being developed after a period of consultation as part of the Social Services Inspectorate report 'Getting The Best From Best Value' (SSI, 2002).

Interprofessional educational developments have also accelerated, with a growth in the number of organisations and networks focussed upon interprofessional development and research (Leathhard,1994,Loxley,1997).Significantly most documented progress has been at post qualifying level. Nevertheless some studies notably that of Tope (1994) have shown considerable support for shared learning during professional training.

A number of programmes of interprofessional education have been established, some involving shared learning, others incorporating an interprofessional model. Leathard (1994, p.24) describes shared learning, as activity that involved a primary educational objective. Secondly it comprised of participants from two or more selected professional groups, in primary or community care. Finally the participants were learning together in a multi-disciplinary context. The Interprofessional educational model whilst including all of the above, is described as having one intended learning outcome centred upon the promotion of interprofessional work (Leathard, 1994, p.29).

From an educational perspective, momentum in higher education has occurred when moves toward competency based, vocational qualifications, particularly in health and social care have been endorsed by governments. Equally the cautious implementation of interprofessional education, namely the maintenance of separate core pre- professional modules of assessment and the application of generic assessment in broader areas of practice in some areas of post professional level, illustrates the desire by most professional registration bodies and their higher education curriculum development groups, to maintain the current status quo.

This position rests on the belief that through facilitating professionals talking to one another this will lead automatically to a greater understanding of other professional roles, which can be implemented as one element of professional training. In taking a simplistic view of the complexities of interprofessional practice and education, its real purpose in terms of changing outcomes for service users may be ignored. For whilst the facilitation of a dialogue between professionals is crucial, the more complex and far less specific issues of professional boundaries, contexts for practice, professional power, problem solving and responding to change remain largely unaddressed. The majority of interprofessional educational programmes have side stepped the processes involved in interprofessional practice with service users. For

as Byne, Cunningham and Sloper (1988, cited in Mathias, Prime and Thompson,1997,p. 119) note, if interprofessional work is to be effective, it needs to recognise that it is the service user that brings together sources of advice into a unified programme. Whilst the extent of this will be dependent on the level of vulnerability of the client in terms of the severity of their problems. An additional factor is the position of the professionals involved in relation to their attitudes, competence and knowledge. As a result, the nature of interprofessional knowledge and its effectiveness in direct client work may need to be addressed as a subject in its' own right. Furthermore the challenges of interprofessional assessment will also need to be responded to and conceptualised (Barr, 1994).

Interestingly only learning disability has a well established pre-professional route, from the Kent project between the Certificate in Social Work studies, (CSS) and the RNMH (Brown, 1994) to that of the RNLD and DipSW, pioneered at Portsmouth and the South Bank Universities. The processes involved in achieving this were far from straight forward, despite the support of the professional bodies in nursing and social work. Whilst a feasibility study in the field of social work and occupational therapy, funded by the Central Council For the Education and Training in Social Work, (CCETSW) in 1996, was to conclude that there were more similarities than differences between the educational requirements of the two professions (Alsop and Vigars, 1996, p.56). However the report also noted that it may not be possible to "Compromise sufficiently on the profession-specific requirements for each award"(Alsop and Vigars, 1996, p.57). Thus although other areas of practice, such as mental health may be in the process of gaining validation, further development towards a integrated model of pre-professional, undergraduate education in health care, remains in it's very early stages in the UK, notably in the new generation project at the Universitys of Southampton and Portsmouth. Although current changes in the councils or statutory bodies for professional practice may challenge this position.

At the same time, the development of the vocational client specific educational pathway has gained ground .notably in the provision of foundation degrees. It will be interesting to note their progress.

2.7 The Challenge for Professionals

Loxley (1997, p.24) writes that to "achieve collaboration, then the word itself must be removed from political rhetoric and the world of common sense where it is too often found."As Biggs

notes (1997, p.192), words like collaboration are used as a form of "self evident truth" in all sorts of policy documents. In terms of the policy context, as Biggs continues, (1997, p.194) current contexts include tendencies that are at one and the same time unifying and leading to diversity. For the professional working at the interface of health and social care, then the policy and political agenda may seem fraught with ambiguity.

Thus a paradox can be observed in terms of the calls for interprofessional practice on the one hand, and the re-shaping of professional structures on the other. Consecutively, the arguments in support of interprofessional practice are posited as efficiency in the use of resources, the removal of overlap in the delivery of services, the clarification of roles and responsibilities and for the client, the delivery of comprehensive and holistic services (Hallett and Birchall, 1992, p.17).Yet such arguments are occurring when both financial and organisational boundaries may act as barriers to good practice. For the professional at the practice interface, interprofessional working may have been presented as a further dilution of skills, and evidence of an increasing anti-professional stance on the part of policy makers (Carrier and Kendall, 1995, p.32).

The role of the care manager in the assessment process of social work practice provides an example of this. Sheppard (1995, p.275) explores the work of Jamous and Peloille (1970). In their dissemination, Jamous and Peloille discriminate between the technical, that is the elements of practice, that can be learnt through a set of specific rules and the indeterminate parts. These components of practice are less certain and require knowledge and experience which are likely to be known only by members of a specific profession. For Sheppard (1995, p.275) this requires and encourages professional autonomy.

What is significant here, is the amount of indeterminacy. If professional indeterminacy is viewed by others, such as policy makers within government, as too high, then deprofessionalising of that area of practice will occur. Further, if the amount of indeterminate knowledge is not adequately generalisable, then the question of relevance can be at issue. In other words, could a non professional have the same amount of knowledge? The traditional role of social work could be viewed as vulnerable, especially when as Sheppard (1995, p.276) notes, the profession has not been very convincing in their claim to specialist knowledge. Thus care management provides an example of claims for a technical approach to practice, alongside a challenge to the specific theoretical base of the profession.

Moves toward interprofessional partnership across all professions, not just social work,

place the individual professional in a dichotomous position. In striving for best practice for service users, their own professional identity may be perceived as at risk. Equally their role as a collaborator within a team may surpass outcomes for service users. Pietroni (1991, p.3) summarises the still relevant issues: conflicts in values and procedures, resource and agency control problems, social defences, unresolved leadership issues and differences between professions mirroring conflicts.

2.8 Professional Power and Interprofessional Practice

Historically interprofessional relationships across professional groups have been affected by the internal struggle for professional status. This struggle has been compounded by the growth of professional hierarchies within individual professions, and the need to lay claim to territory in respect of service user groups or areas of practice. In achieving professional status a specific professional group will have achieved social closure (Hugman, 1991 p.82). This can be summarised as the route that social collectives aim for, in order to maximise reward, and achieved by restricting access and resources, to a limited group of eligible individuals. Hugman disseminates Weber's concept of closure drawing on the work of Parkin, (Parkin, 1979, p.86) who offers two forms of closure; exclusion and usurpation. Exclusion occurs when a group is successful in preventing access to specific resources. This occurs when the group can lay claim to ownership or control over specific property or credentials (Parkin, 1979, p.86). Usurpation happens as a result of a group's attempt to form in response to exclusion, as a direct move to overcome it. In Parkin's work, professionalisation is an example of exclusionary closure. In other words the more successful an occupation has been in gaining control over the establishment and those entering it to acheive qualifications, the higher the degree of closure achieved (Parkin, 1979, p.86).

This is of relevance when interprofessional practice is examined, as not only does closure determine who will enter a professional group. It is also significant in determining the boundaries for practice and in claims for power over other professional groups (Hugman, 1991,p.83). As Carrier and Kendall (1995, p.16) observe, the history of failed collaboration, in some areas of community care is partially entangled in issues of professional power. Kneale (1994, p. 152) citing Thompson (1987), indicates that organisational structures of the health service can be viewed as a set of coalitions, each with its own agenda. Underpinning these organisational boundaries are dominant coalitions , which set the boundaries. For Kneale , these

coalitions hold power and this power can be hierarchical.

When individual professions are viewed, the historical development and dominance of the medical profession and its hierarchical position in health work provides an example of this (Jones, 1992). Further the exclusion from, and claim to areas of practice, of other professional groups including nurses and social workers have also impacted upon interprofessional work. Bond (1997, p.90) records the impact of hierarchical structures on interagency collaboration, observing that in many teams "collections of individuals who are separated and connected by relationships and power, and the differential statuses achieved by professional bodies and employment sectors, additionally shape the power relationships within teams." Equally interprofessional work can be seen as a threat to professional power, leading to a retreat to safe, singular professional boundaries (Kane, 1975). The impact of such structures on practice can also lead to a reluctance to share information, which may be compounded if areas of practice have been hard fought for, by a professional group with a lower status (Carrier and Kendall, 1995, p. 15).

2.9 Professional Power and Organisational Roles in Collaboration

Such power relationships may become even more complex, when agency structures are addressed in relation to collaboration. Hudson, Hardy, Henwood and Wistow, (1999, p.238) have explored the complexities of collaboration in the public sector, which raise a further set of issues for professionals working in separate agencies, who come together to work on joint projects.

In their discussion, Hudson and his colleagues draw attention to the limits of organisational individualism. They argue that increasingly solutions to problems need to be addressed from a range of perspectives, as the incidence of clients with multiple needs rises (Hudson et al, 1999, p.238).Further from an agency point of view, collaboration may pose a threat, as agencies may loose some of their freedom to act independently. Additionally organisations may have to invest scarce resources when the return on investment may not be clear (Hudson 1987). Citing Huxham and Macdonald (1992) , Hudson et al (1999, p. 242) add that collaboration may mean having to share the credit for a particular outcome or even letting another organisation take all the credit. This may impact on the enthusiasm for collaboration in some small teams within particular sectors of health and social care organisations, and who may be constantly at risk of usurpation both internally and externally.

2.10 Professional Knowledge and Interprofessional Relationships

A further key area of difference in terms of professional collaboration is the way in which different professionals perceive knowledge. This difference is reflected in the type of professional models members of a particular group adopt. Hey, Minty and Trowell (1996, p.202), summarise these four models as: the practical professional, where problem solving occurs through trial and error, and competence is gained through experience. The expert professional where the professional claims to know, keeps his or her difference and seeks acknowledgement of high status based on this claim to knowledge. A managerialist model in which at a higher level leaders apply expertise in planning and decision making and which are then implemented by lower level practitioners who perform tasks. Finally the reflective model within which the professional recognises the contribution of the client or patient and other professional, and the learning that can take place through this process . In relation to teamwork, those in medicine have largely taken on the expert role, ensuring a legitimate claim to practice in a particular form of intervention (Friedson, 1970). On the other hand other professional groups such as social work and nursing have opted for a more reflective model of practice centred on empowerment of the client or service user, which has in turn led to criticisms of the lack of specialist knowledge of these groups.

This concern with knowledge application impacts on intra- and interprofessional relationships in a number of ways. Initially in terms of negotiating professional boundaries and ensuring problems are solved within the professionals' area of expertise (O' Neill and Duffey, 2000, p. 224). This knowledge is described by Friedson (1986, p. 224) as part of a professions literature, used to communicate underlying knowledge to other members of a profession.

The nature of this knowledge may impact on the value placed on it. For example in nursing knowledge has two components, nursing science or research (Donaldson and Crowley, 1978) and nursing practice knowledge. Nursing practice based on less tangible aspects of intervention such as personal knowledge and that of other disciplines may be seen as separate and less meaningful than nursing science. Likewise social work has been criticised for its lack of formal knowledge (Hey et al, 1996, p.202). The tension for professionals working in practice has been explored by Schon (1983) who suggests that the positivist elements of epistemology are still present in institutions, creating hierarchies of professional knowledge and compounding the difficulties of problem solving in practice.

One effect of competing levels of professional knowledge, is that in team work claims

to particular areas of knowledge and legitimisation at national level, may result in challenges to professional role at local level. Maintaining a presence for political reasons may be seen as a driver for involvement in a particular case. Consequently it may not always be the most appropriate professional who provides intervention.

Likewise claims to expert knowledge may legitimise power, particularly in the well established professions where knowledge has a formal, traditional scientific foundation. Payne (2000) writes that someone with expert power may assume that this automatically gives them high legitimate power, and others may allow this to be the case, leading to further sources of conflict in the team work setting. Reinforcing the negative view that for one person to gain power another must loose it in the team work setting.

2.11 Knowledge and Expertise

The search for theory generation for practice has engaged researchers and practitioners alike in the fields of nursing and social work. Fook et al (1997, p.406) cites Saleebey (1993) and the concern for social work to develop theory which is relevant to practice. Carper (1978) writes of the function of nursing knowledge as the basis of nursing intervention. Accountability and a desire for professional standards are one reason (Cooper, 1992). Whilst Loxley (1997, p.53) writes that there is a possibility that nursing and physical therapies are equipping themselves to have some control over their destinies in the move towards higher education. The concern with expertise in nursing (Jasper, 1994) may be an example of a professional group seeking to further claim an area of legitimacy and a desire to use prescriptive power over other professions. The development of nurse consultant posts as part of the current governments modernising agenda being one example (DOH, 2000). Likewise as Loxley observes (1997, p. 53) social work is under threat in some areas of practice, due to nursings new knowledge and practice claims in the areas of health and the social factors that impact on it.

2.12 The position of the Professions

The field of child protection provides an example of legitimisation in the framing of professional boundaries. Sheppard (1995, p.38) charts the place of the social work profession in the field of child abuse. He acknowledges the position of social work in this field as a legitimate one, stemming from the recognition of child abuse as a problem by society. This is marked by the institutional acceptance of these problems, and the steps taken by the profession

to pursue this area of practice and lay claim to it. Further the social work profession's key role is in carrying out a role specified by the state and set within the legislative framework of the Children Act (Sheppard, 1995, p.39). Consequently social workers must collaborate with other professionals in this field of practice, as in acute mental health, where the professional role is clear. As Sheppard summarises " the core framework for these functions lies in the law and in the rights and duties which constitute roles which the social worker is expected to carry out." In contrast the role of other professional groups in the health and social care arena has been more ambiguous, notably the position of health visitors and community nurses, whose role has been questioned in the light of the NHS reforms (Hiscock and Pearson, 1996, p.24).

In the case of the primary health care team issues of difference may be compounded by the status of the GP compared to other professionals, where the GP is legally accountable for the welfare of the patient. A consequence being that the GP may automatically be seen in the leadership role in the interprofessional context, where occupational tensions may not become overt (Evers, 1981, p.208).

Such differences in the perception of some professional groups, regarding their own and others position in the organisational culture, can impact on collaborative practice. Dalley (1989, p.113) refers to the way in which a group may view itself as distinctive, and as being characterised by a particular set of behaviours and attitudes.

An acknowledgement of issues of power and status within practice is crucial. For interprofessional collaboration, any attempt to work across the boundaries of health and social care needs both to recognise and be responsive to the concept. For whilst medicine may be viewed as the most dominant professional group, tensions within the profession itself exist. Loxley (1997, p.52) describes the subdivision of specialities in gerontology, where competition for professional domain has led to the positions of psycho-geriatrician, "standing between psychiatry and geriatrics"

The legacy of the internal market remains, and the advent of PCG s and the impact on hospital trusts have created uncertainty. Further as Loxley (1997, p. 54) writes the changing nature of the practice interface must be acknowledged, and the fluidity of situations noted where, "nothing is given or permanent".

2.13 Professional Boundaries and Identity

Making assumptions about leadership in the interprofessional context is one example of the

impact of the occupational culture. Loxley (1997, p.55) defines the occupational culture as "that collection of shared assumptions, custom and practice, models of reality which mark the boundaries between those who belong inside and those that belong outside."Those professionals that remain outside of a particular professional group are likely to be stereotyped from those within, who may develop negative views of the value of the other professional group's skills (Loxley, 1997, p. 55). Those that remain within the group will share a set of values based on their professional socialisation experiences. Their collective experience will be underpinned by a particular set of views or beliefs concerning the client or service user group, supported by theoretical models of practice.

These in group processes, promote the development of a shared or professional identity (Tajfel, 1981). In addition they promote the "orthodox" position of the profession (Hugman, 1991, p.206).Through the adoption of this stance, the perpetuation of the bounded core of the specific profession remains intact, and as Hugman notes, maintains the professions bid for autonomy (1991p.206). In this context, professional life is a claim to authority and high ethical standards, as Carrier and Kendall (1995, p.11) record.

Group identity along with the integral norms and values of the profession are crucial in maintaining professional confidence. They are responsible for the frame of reference for practice (Loxley,1997, p.56) , and for measuring the performance of other external professional groups. However in cases where professional boundaries are ambiguous or there is a lack of clarity regarding professional roles, tensions may occur. Returning to the nature of professional knowledge, Sheppard (1995, p.31) draws attention to the ongoing debate within social work relating to its theoretical foundation. The diversity of views of social work practice, from that of social functioning (Bartlett, 1970, p.70), where the individual is supported to cope within an environment and or life transitions, such as old age, through to empowerment (Sheppard, 1995,p.29), which is concerned with power, individuality and choice. The result being criticism from those outside the profession who suggest that social workers do not really know what they are about (Sheppard, 1995, p.31).

When professional boundaries are discussed, the credibility of a professions members may be perceived as at risk, even when service improvement is the likely goal or outcome. Biggs (1997,p.196) observes that "seamlessness" can initially be seen as increasing pressure toward a merger of professional roles, threatening professional identity. This can lead to defensiveness and rivalry at the point of interprofessional collaboration. Professional groups

may operate competitively for status and resources, whilst forging relationships that work in opposition to client need (Biggs, 1997, p.198).

2.14 Professional Values

Conflict or interprofessional tension are of specific interest when values and attitudes are addressed. Bines (1992, p.128) cited in Barr (1994, p.97), discusses competence based education at professional level. He argues that such innovation may increase flexibility for professionals. However the extent to which professional education and subsequent socialisation, has impacted upon professional culture and values may be underestimated. Braye and Preston Shoot (1994) suggest that to ignore professional values will lead to greater tension in interprofessional teamwork.

In the practice setting assumptions may be made about the commonality of individual professional values, despite the different professional socialisation experiences of team members Beattie (1994, p.118) describes the broad span of social ideologies, values and ways of working that contemporary health promotion encompasses. One result being that there is no "master narrative" that commands universal assent. The danger of such diversity may be greater anxiety and stress for professionals (Woodhouse and Pengelly, 1991), compounded in practice. Where other elements of difference, created by status or hierarchy, also inhibit individuals from presenting a particular set of professional values This can in itself create a rift (Leathhard ,1994 p .212).

2.15 Professionals and Service Users

The nature and forms of power used in interprofessional practice may also impact on the service offered to service users. Energy is directed toward maintaining professional territory at the expense of service user need (Biggs, 1990, p .23). Paradoxically, professionals are also diverted by the building of positive relationships with each other (Loxley, 1997). Reason (1996, p. 237) explore the concept of empowerment and its impact on professional roles within the primary care team and in case review meetings. He notes concerns from practitioners in relation to differences of opinion over diagnosis or therapy, and the insecurity felt in challenging another professionals intervention, particularly in the client or patients presence. These feelings may be seen as dis -empowering to the professional groups. Thus there may be tension in relation to achieving empowerment for service users within interprofessional practice

where the status of some professionals may be viewed as less significant.

Opie (1997, p.260) develops her theoretical framework from Foucault's (1978) work on discourse and power. In his work Foucault argues that particular disciplines or discursive practices (Opie, 1997, p.260) are favoured in institutional or other contexts. The effect of which is the dis-empowering of other disciplines or discursive practices in the same institutional space. Through this process, dominant discourses define reality through the representation of truth. This reality is not static, as many other discourses operate simultaneously and can be challenged. Key features of this representation of an event, point directly to the discourse or discourses used, one of which is language. Opie cites Atkinson (1990) and emphasises that language can not be seen as a neutral or transparent medium, because of its function as mediator in an event and its representation. Because of this mediation role, no account can ever be complete. There are always other narratives or accounts, which make for alternative interpretations, based upon other constituent factors. As a consequence, language being one means of representation of an event, is linked to, and embedded in, relations of power (Opie, 1997, p .261). In her discussion Opie presents the competing representations at work, and explores the difficulties this created for an interprofessional team. The team were not positioned supportively with the client, and the more difficulties the team faced, the more they were unable to share their representation with the client.

This is significant for Opie, because teamworking to involve clients is more than a question of structures. It is about acknowledging the inevitability of differential power relations and the development of ongoing critiques to explicitly minimise that difference. Effective teamwork especially where client needs are complex, is based on teamwork moving beyond the immediate, observable physiological need, and seeking to work reflexively to support representations of the client that incorporate emotionality (Opie, 1997, p.275).

2.16 Interprofessional Practice, Policy and Power.

The changing conditions of practice have set in place a number of responses from practitioners, which ultimately underpin relationships with service users. A series of complex policy, organisational and professional boundaries may inhibit progress, and have led many professionals to develop strategies in maintaining or striving for power, rather than real empowering practice. And whilst practitioners in the newer professions of nursing and social work have the opportunity to develop practice and practice relationships in long term health

and social care, some may have yet to gain a real understanding and experience of the nature of power in interprofessional relationships both for themselves and with service users.

Discussion so far has shown that there may well be different value placed on joint activities in agencies. Hudson et al (1999, p.246) suggest that some assessment of the potential organisational capacity for collaboration may be helpful. This could involve exploring the links between strategy, culture and change (Meek, 1988). Citing Newman, (1994) Hudson et al write that the usual means of doing this would involve strategy first with cultural change following. However culture is there before strategy, as culture is the organisation or agency. Therefore when addressing collaboration there are two important implications. Firstly that of conflicting values, which are linked to different forms of power and the existence of multiple power bases (Hudson et al, 1999, p.246). Secondly and linked to this, the fact that change challenges existing practices and values, resulting in ambiguity around managerial versus professional regimes, flexibility versus bureaucracy and collaborative versus department loyalty. Ultimately the ways in which individual practitioners respond and deal with such challenges, in the decision making process impact on the likely success or failure of any future strategic collaboration. These tensions and professional responses to them, will be explored further in subsequent chapters.

Chapter Three
Learning Disability and the Context of practice

The field of learning disability has been an area in which substantial calls for collaboration and interprofessional working have been made. A number of conflicting and contested claims for professional domination have been played out against a backdrop of minimal service budgets. The ideology of normalisation may have influenced a policy agenda centred upon user rights, physical and social integration, yet critics note the tensions of resource allocation set within an individualised pattern of service design. Historically, differences between the medical and social models of practice have impeded progress, whilst the continuing marginalisation and oppression of this group of people calls into question the values of public and professional alike. In this chapter the position of people with learning disability, and the professional groups that support them, will be considered with specific reference to long term support and in the broader context of historical policy development, service delivery and interprofessional collaboration.

3.1 Historical Perspectives

3.1.1 Controlling People with Learning Disability

Porter (1983) writes that the mentally disordered, were dealt with in a relatively informal manner, and it was not until after the poor law amendment act of 1834, that the development of large scale institutions, based on workhouses was to begin. The Victorians soon organised separate systems of asylums, as theories which incorporated cure for mental deficiency and insanity became prevalent. Initially these two groups of people were accommodated together, whilst the early claims of the medical profession to scientifically classify and treat cases, soon led to distinct service provision. Simpson (1999, p.149) notes the work of Seguin (1866, p. 39) who defined idiocy, adopting an organic aetiology, (Simpson, 1999, p.150) within which the functions of the body were the focus of treatment. Seguin's model of intervention was based on pedagogy, training the muscles, senses and intellect, not in order to improve social or scholastic functioning, but to ameliorate the condition itself (Simpson, 1999, p.150). The work of Ireland (1877) was to follow, exploring pathological effects of idiocy in more detail, through

sequential classifying and categorising. Those in institutions were used as experimental subjects (Simpson,1999 p,151).

Foucault (1975) addresses the suppressed elements of order, suggesting that society and its identity can be defined through a study of those excluded. In his work on the history of sexuality, (1978). Foucault notes the emerging interest of professionals in the thought processes around sex and sexuality. Medicine in particular was preoccupied.

In the treatment of people with learning disabilities, the role of the institution as a quarantine, as part of prevention of the spread of deviancy through the eugenics movement, was seen as a way of controlling the expression of sexuality and reproduction. Through this process professionals labelled and categorised individuals as sexually promiscuous or morally disreputable (Scull,1984 p. 29), as a rationale for such treatment. Foucault writes of the professional discourse, within sexuality, and links this discourse to power (1977). Thus what is said or documented, deepens professional mediation into everyday life.

Other groups of professionals have also influenced and controlled the behaviour of others. Institutions often housed uneducated women labelled as "feeble minded" who had children outside of marriage. Their punishment was lifelong incarceration, under the control of the medical and bureaucratic systems of power(Simmons, 1978). Women with learning disability were perceived as idiots who were sexual innocents and in need of protection, or as a threat, due to their undisciplined sexuality (McDonagh, 2000, p. 49). For as Scull writes, referring in general to those labelled as deviant, (1984, p. 33) the "treatment of those so confined served as an omnipresent example, a reminder to the rest of us of the awful consequences of inability or refusal to conform".

3.1.2 The Growth of the Asylum

The number of people incarcerated was substantial. In 1859, the county asylums held 16,000 patients, but the passing of the 1913 Mental Deficiency Act, underpinned by the Royal Commission (Radnor) in 1908 (Walmsley, 2000, p.66) set out society's position: "Our investigations compel the conclusion that there are numbers of mentally defective persons whose training is neglected, over whom insufficient control is exercised and whose wayward and irresponsible lives are productive of crime and misery, of much injury to themselves and colleagues, and of much continuous expenditure wasteful to the community and individual families" (Royal Commission, 1908, cited in Walmsley, 2000, p.66).

The influence of the eugenics movement with the desire to sexually regulate women particularly poor and working class, was a key factor in the increasing institutionalisation of people described as mentally defective. Men were also detained but for unlawful rather than sexual behaviour (Walmsley. 2000, p. 68). The 1913 Act meant that local authorities needed to find accommodation for an increasing number of people and by 1939, public authorities were providing 32,500 beds for mental defectives. Another 6,000 were cared for in the workhouses. Together with those categorised as lunatics, a total of 200,000 were receiving mental care in 1939. Not all those institutionalised were in large institutions. Catholics were housed in religious houses, and some women lived and worked in smaller laundry or 'Magdalen Homes' (Stevens, 2000, p.74). These homes were aimed at the 'washing away of sin'. A form of municipal institution, they were run by medical superintendents and focussed on efficiency (Stevens, 2000, p.74). Other smaller forms of incarceration were approved and certified as houses. These were smaller and reliant on private fee paying patients (Stevens, 2000, p.74).

Further as Walmsley and Rolph (2001, p. 59) write, there has been a tendency in the documented literature to assume that institutional care has been seen as the most prevalent and most negative form of service provision for people with learning disabilities before the 1950s. Suggesting that this may be due to the physical presence of the asylums in contrast to community alternatives, Walmsley and Rolph (2001, p.61) also note the lack of archive documentation in relation to community provision.

For whilst the early 20th century did see an increase in the promotion of institutional care set within the 1913 Mental Deficiency Act (Walmsley and Rolph, 2001, p. 65), a system of licensing was set in place which provided a formal framework for community care. This involved the appointment of guardians, who might be parents or relatives, and without which the local authority would not pay financial assistance (Walmsley and Rolph,2001, p.66). Additionally such families who were in control of people with learning disabilities were regularly scrutinised, on a quarterly basis in terms of both their ability to care and also to control. This was seen as particularly important in relation to the supervision of relationships with the opposite sex (Walmsley and Rolph,2001, p.68). Provision of supervision for those who were not seen as dangerous or as a threat to society was minimal (Walmsley and Rolph 2001, p.68). Thus as Walmsley and Rolph note it is more helpful to see community care and institutional care as on a continuum, and to note that community care itself was also about care

and control between 1913- 1946 (Walmsley and Rolph, 2001, p.59). Significantly guardians or relatives were also means tested and expected to pay a contribution to the cost of care in institutions if they were able, or within the community for their relative to attend a day or occupation centre if a place was available (Walmsley and Rolph,2001, p.67).

However, the 1913 Mental Deficiency Act was successful in the promotion of institutional care (Walmsley and Rolph,2001, p.67) for people who were classified as defectives, and despite the presence of community care, half of the hospital beds taken over in 1948 at the establishment of the National Health Service were for people described and categorised as the mentally defective or insane.

Whilst in mental health services the asylum was in decline from the 1950s, this was not the case for mental deficiency institutions. Stevens (2000, p.72) notes that "Until the 1970s, social workers accepted that institutional care was the appropriate solution, when families were having difficulty with a disabled child" (Stevens, 2000, p.72).

3.2 Attendant or Professional? Nursing and the field of learning disability

Prior to the 1890s, staff in asylums had been largely described as attendants for men and nurse for women. In the asylum men traditionally dominated the workforce, partially due to the need for physical strength if people had to be restrained. Equally due to the conditions in the asylums, it was difficult to engage kind and creative employees. Many staff would have been unemployable elsewhere. From the 1890s, the shift in medical practice offered the opportunity to lay claim to areas of practice, for a number of potential professionals. Scull writes "the proto professions could develop at the very least empirically based craft skills in the management of particular forms of deviance" (Scull, 1984, p. 29). These skills could be used to lay claim to particular areas of "dirty work" and the start of professional autonomy (Scull, 1984, p. 29). A rekindling of interest in the use of treatment based on medical or physical therapy, as an alternative to moral treatment, saw a shift towards general hospital regimes. Employees were to be educated in biology, within a nursing hierarchy. The National Certificate introduced in 1891, offered a medical superintendent dominated curriculum, which was developed in 1893 and in 1896.

The Medico-Psychological Association (MPA) scheme was on offer to all attendants until after 1913, when the Mental Deficiency Act revisited the idea of a separate course for mental deficiency nurses. A separate route to qualify was made available in 1919, by the

General Nursing Council (GNC). At the time most attendants stayed with the MPA as it was cheaper to register (Mitchell, 2000, p.78) and supported by the medical superintendents. The training options available in the MPA scheme were bedside nursing, occupational therapy, crafts training and industrial therapy (Mitchell, 2000, p.79). An ongoing battle between the MPA and the GNC for control of certification of nurses occurred through out the 1920s and 30s.The domination of medicine and the growth of unionisation meant that the MPA (Royal Medico Psychological Association, RMPA from 1925) gained ground (Dingwall, Rafferty and Webster, 1988, p.132), despite the GNCs desire to see nursing as a unified profession.

This desire was more about the recapturing of practice in areas dominated by medicine, than an interest in the needs of people described as mentally deficient. Dingwall et al (1988, p. 132) write that the GNC had few members on its register working in the field of mental deficiency, whilst the separation into specialist categories was viewed as an imputation of inferiority. The less valued status of the group was summarised by the GNC board of control : "Nurses adequately trained in the nursing of mental diseases have had in their course of their training sufficient experience of mental defectives to enable them to assume the responsibility of nursing and taking charge of mental defectives. The converse does not hold good, for there are many emergencies and propensities arising in mental disorders, (from which mental defectives are largely exempt) how to meet and guard against, which nurses can only be taught by additional experience" (Byrne, 1920).

Mitchell (2000, p.79) records that this group of practitioners and their position was questioned and misunderstood. Herringham (1926) records 'mental deficiency nurses had no claim to be called sick nurses at all." Whilst divisions between mental illness nursing and mental deficiency were also ongoing. Mitchell (2000, p.79) notes Cowlins' response in 1926. "It (mental illness nursing) is helping to restore the damaged mind. You can't restore mental defectives. It is not like mental. It is an education problem only".

For more ideological reasons, other key figures in the field of mental deficiency also had concerns about the link with general or sick nursing. Stevens (2000) describes the influence of Margaret MacDowall, who ran several small homes for children and adults with learning disability. Her ideas were published as part of the nurse training handbook (RMPA, 1931, p. 428), and dispute the link with sick nursing. "I think the main reason is that the cure is the main idea in nursing of sickness, whereas in the nursing of the underdeveloped, what the world calls cure is rarely obtained, and people who aim for this get dissatisfied, by their inability to get a

definite end....." (MacDowall, 1924, p.42, cited in Stevens, 2000).

Where there was disagreement on models of care, the GNC had little impact on the numbers of employees taking up professional registration, and care practices remained institutional in nature. The development of the NHS in the 1940s , was to bring about a major shift in mental health nursing and practice, culminating in the 1959 Mental Health Act. However in the field of learning disability the GNC had to further reconsider the worth of bringing in the "Mental Deficiency Nurse" into the nursing regulations of 1945 (Mitchell, 2000, p.79).

Whilst in mental health there were complex but largely therapeutic reasons for the contraction of institutions, inertia remained in the field of learning disability (Ryan and Thomas, 1980). In terms of staffing, there remained a core group of institutional based staff , still made up of more than 45% untrained, with an ongoing dispute over pay and conditions. Additionally resources were restricted, as institutions were allowed to run down. Conditions affected recruitment to nurse training in the field of learning disability, and concerns over care in institutions were once again raised. The committee of enquiry into conditions at Ely hospital (DHSS, 1969) was the start of a decade of discomfort and a questioning of the nursing role.

3.3 The Place of the Registered Nurse

A further questioning of the appropriateness of the Health Service for the ongoing support of people with learning disability was to occur within the Briggs Committee's report (1972). This committee was charged with a review of the nursing profession as a whole. In its findings the report suggested that the place of the Registered Nurse Learning Disability RN LD, in nursing was to be in the short term only and that ultimately a new profession should emerge as service design and delivery changed (1972, p.72).

More radical changes were to be suggested with the publication of the Jay Report in 1979.This report on Mental Handicap nursing and care, once again questioned the relevance of the current service provision for people with learning disability. Recommending the transfer and responsibility for this group to social services, it also sought a change in the type of worker that should provide care. This new professional would have skills in both health and social care and would be educated through the Certificate in Social Services (CSS) programme. A clear message from the Jay committee was that gaps in provision of care needed to be addressed, and one way of achieving cross boundary working was to equip workers with the

skills from both professions. In making these recommendations an acknowledgement of duplicity of skills in the field of nursing RNLD and social work was made.

The status quo was to remain until the1980s when the professional body for nursing, (English National Board) developed a new nurse education curriculum for the learning disability nurse. Its foundations were underpinned by a social model of care based on the principles of normalisation (Wolfensberger, 1972). The outcome of which was a severance from other branches of nursing, based on the medical model and focussing on the nurse client interaction, with only a brief concern for environmental and structural factors.

3.4 Tension and Threat

The ideology of normalisation and social role valorisation conflicted with professional practice, as the knowledge and skill base of the group was examined, in a questioning of the need for a specialist nurse. For the RNLD two decades of tension were to follow as the debate about identity continued. Mainstream nursing, always the reluctant partner in this field of practice, offered professional inclusion at the cost of values and beliefs in relation to the "client". Professionalisers amongst the RN LD group sought to maintain allegiance with the core nursing group, creating rifts with those nurses seeking to work to more empowering models of practice.

Equally social care and support underpinned by the social sciences, was the domain of social work. Pietroni (1994, p.83) citing Bligh (1979) writes of the tribal nature of the professions. In this context, those members of a particular professional group, who take on the reality constructs of another "tribe" may be threatened with exclusion. For the RN LD members seeking to work more inclusively with clients, this resulted in a period of isolation and vulnerability in which sanctions were imposed by other groups of nurses. This was illustrated by the lack of interest of major nursing organisations such as the Royal College of Nursing (RCN) in the threat to the future of this group of nurses.

In addition, social policy (The Community Care Act, 1989) supported the position of the social worker as the lead agent in the provision of care for people with learning disability. The experience of the RN LD placed the professional groups claim to practice under scrutiny. Security of identity was at issue, when merger with a bigger group, in this case, the rest of the nursing profession was offered. Equally the threat to identity was also present when immersion in the wider and less well defined group of social work was likely (Biggs, 1997, p.188).

Perceived challenges to the RNLDs professional boundaries, both internally and externally, meant that the credibility of groups members was at risk. Even when service improvement was the stated goal or outcome. Biggs (1997, p.196) observes that "seamlessness" in this case the support of people with learning disability in accessing ordinary services, can initially be seen as increasing pressure toward a merger of professional roles, threatening professional identity. Further the introduction of Project 2000, (UKCC, 1986) with a common foundation programme for all nursing branches, followed by specialism was seen by some of the RNLD group as another element of marginalisation of the profession.

Difference and conflict within the RNLD group, especially when limited resources were at issue, did not help its status. Nor did evidence of more effective practice emerge from the new educational model. What was facilitated was a framework for a joint programme of theory and practice leading to the dual award of RNLD and DipSW. The University of Portsmouth developed and offered the first programme in 1991.

The ongoing search for a collective agreement on role and value base for the RNLD continued, culminating in The Consensus conference in 1993. This Department of Health initiative had as its central focus the question of what type of worker should support people with learning disability in the light of community care and a mixed economy of welfare. The outcome as described in the Continuing the Commitment document (DOH, 1995) was a continuation of the RNLD. Together with approval for the joint nursing and social work qualification, which had been offered in an experimental form at two universities (Portsmouth and the Southbank), to be further developed. At this point the withdrawal of the single RNLD award had been an option, yet was retained by the Department of Health.

3.4.1 An ideological U turn

Most of those within the professional group of the RNLD were satisfied with this outcome at the time, and as Parrish and Kay note, "Nurses must now develop and refine existing skills to match client's need" (Parrish, and Kay, 1998, p. 478). The Cullen report (DOH,1991) had set out a clear role for community learning disability nurses, whilst more recently, Signposts for Success (DOH, 1998) affirmed the role of the RNLD in the commissioning and providing of services within health care.

Consequently the ongoing demarcation of health and social care and the resultant resource transfer has led to a "U" turn on the part of the majority of RNLDs with most

reclaiming the "Healthcare" elements of practice, meeting the needs of individuals with complex or challenging behaviours. Others working in social care and are no longer able to practice many core nursing skills, and their future remains uncertain.

3.4.2 Power and the RNLD, the place of the client in Learning Disability services

The RNLD group, has directed its energy to position itself as both the champion of the needs of people with learning disability, and as the legitimate expert group to provide care and support. However the position of the RNLD group themselves may not have always been powerful. Turnbull (1999, p.13) suggests that the constant struggle for a professional status and role, by this group of nurses throughout their history (Mitchell, 1998, p.45) indicates that they themselves are marginalised. It is only through an acknowledgement of this marginalisation and dis- empowerment that the RN LD group can move forward.

The contradictory nature of these positions has remained until recently, largely unexplored within the field, and for the major part, of limited interest to other policy makers, advocacy groups and professionals who offer short term support. A series of contradictory discourses may be in operation which will be explored in further detail here, in an attempt to address both the success or failure of the RNLD group this far, and the likely impact on the marginalised group of people with learning disabilities.

During debates questioning the need for the RNLD, a common anecdotal refrain has been " who else would care for this group of people and their families?". The use of such collective altruism (Kelly, 1998, p.80) as in medicine, draws attention to the need for a specialist professional, in the absence of a critical review of the function of the RNLD and their status in the professional hierarchy.

Firstly, the position of the RNLD and their facilitating role in the route to inclusion of people with learning disability in mainstream society. Underpinning professional practice and specialist skills of the RNLD is a set of values that "aim to help people who have learning disability to be ordinary people living ordinary lives (the normalisation principle)" (Norman, Redfern, 1996 p.159). Based on the Scandinavian models of care for people with learning disability, Normalisation or the more recent Social Role Valorisation (Wolfensberger, 1991) offer a set of ideologies based on the design of culturally valued services, offered by culturally valued means (Wolfensberger, 1972). This ideology, which endorses physical and social integration, rights and choices along with opportunities for self development centred on skills

and competence, has been the guiding principle for service development, and a great deal of staff training and education.

3.4.3 Normalisation and its influence

Gaining interest, at the start of the de-institutionalisation movement, Wolfensberger's ideas were thought provoking and radical. Operationalised in practice through a series of models or tools, such as PASS (Wolfensberger and Glen, 1969) PASSING,(Wolfensberger and Thomas, 1983) and the five service accomplishments (O' Brien, 1987) they offered creative and still powerful means to change. The position of individual people with learning disability as historically devalued, powerless, and marginalised was central to Wolfensberger's thesis, whilst his idealist suggestions for empowerment were to be viewed as controversial, within the economic reality of community care in England and Wales, and the notion of community presented. Inevitably dilution and misinterpretation of his ideas has taken place, and as Tyne (1992, p. 45) observes the critiques of normalisation have happened at some remove from the lives of people with disabilities.

Gilbert (1993, p.1605) has also criticised the learning disability nurses use of normalisation. Drawing attention to the increasing role of the market in determining resources, such as in care management, and the reliance of individuals with learning disability on welfare benefits, he argues that there are likely to be increased poverty levels and reduced potential for empowerment for this group. In his thesis, he suggests a shift in paradigm for the learning disability nurse, from normalisation to materialism. Through making this change, nurses could work more effectively to both recognise power relations and within them, "Work to identify and promote opportunities" (Gilbert, 1993, p.1608) which might recognise self definition and organisation.

Gilbert's critique has yet to be addressed by leaders in the RNLD group, with normalisation remaining one of the guiding philosophical models for practice in the RNLD curriculum. Individualised care remains at the centre of practice development, whilst the focus on empowerment of individuals, through meeting needs, making choices, enhancing competence, and risk assessment are all currently central to the RNLD role. The language of curriculum documents, endorse this, whilst policy documents such as Signposts for Success (DOH, 1998) and Facing the Facts (DOH, 2000) draw attention to the role of the specialist nurse in relation to meeting individual need.

Despite such intentions, the RNLDs claim in providing specialist support and meeting individual need, is founded upon both addressing and reinforcing a specific view of the person with learning disability. Simultaneusly maintaining a commitment to the principles of ordinary life, in ensuring participation of people with disability in competence development, choice making and community activity, whilst restricting options for autonomy through the management and control of more fundamental daily living and lifestyle choices. For example clients in residential homes may well be involved in choosing the decor of their bedroom, but have limited autonomy in terms of how, with whom or where they live. Limited societal responsibility is offered.

3.4.4 Individualised Approaches to care

Simpson (1999, p.155) uses individualised programme planning (IPP), a tool which " typifies the close equation of competence enhancement with service function and success" to demonstrate a lack of connection between concepts of competence and liberty. He argues that there are two ways in which this may be the case. Firstly when it is a direct desire for example I want to learn x , or secondly when it is a means to an end such as "I want a place of my own, so I need to learn how to" (Simpson 1999, p.155). The dangers of making the liberty, competence link self evident, are twofold. Inevitably assumptions are made about competence enhancement and less professional presence, which for some people with profound disability is not going to be the case. Further, it reinforces the view that there is nothing wrong with the nature of the relationship between professionals and people with learning disability. As Simpson observes this is "because they are the inevitable result of the learning disability"(Simpson, 1999 p.155). Subsequently competence is not liberation for people with learning disability, but it could form some part of it, for certain individuals.

Whilst Simpson is referring to professionals in a generic sense, the role of the RNLD in skill development, and the more recent support with "challenging behaviour" can be placed under scrutiny. A concern with technological approaches, that is objective or goal setting, and the role of the RNLD as broker or manager of these processes, may give legitimisation to Habermas' technocratic consciousness.

Waitzkin (1991, p.18), refers to Habermas, who observes that scientific ideology, has defined an increasing range of problems as amenable to technical solutions. As a result,"scientific ideology tends to depoliticize social issues by removing them from critical

scrutiny" (Habermas 1970, p. 82), and science legitimises current patterns of domination, including more traditional class relations. Waitzkin (1991, p.18) cites Habermas: "Technocratic consciousness is, on the one hand, "less ideological" than all previous ideologies... On the other hand today's dominant, rather glassy background ideology, which makes a fetish of science, is more irresistible and far reaching than ideologies of the old type"(Habermas, 1971 p.214). For Habermas, domination can then be justified as being in the interest of another class, whilst at the same time repressing another class's partial need for power. Therefore in the workplace, macro level technological organisation can legitimise domination through cultural symbols, whilst at the micro level interpersonal relationships, based on domination, create distorted communication. Whilst Waitzkin criticises Habermas for the abstract nature of his ideas and a lack of evidence, he suggests that Habermas' argument in relation to communication and its distortion, encompass one to one encounters in a medical setting (Waitzkin, 1991 p.18). He writes "to the extent that doctor patient interactions convey ideologic messages under the rubric of medical science".

Therefore attention is deflected from the ongoing legitimisation of professional domination, by a reliance on medical science, by both patient and doctor, and communication is further distorted through the device of language. Thus this discourse of medicine continues to reproduce a scientific ideology (Waitzkin, 1991, p.19).

3.4.5 Legitimisation and Practice

Models of practice of the RNLD may present an example of the legitimatised domination of professionals and people with learning disability. Policy documents recommend a structured individualised plan of action for each person. Intervention is based on need, following an assessment process. The RNLD will both interpret and carry out the agreed plan of action, with attention to the recording, auditing and evaluation of activity. As such following the protocols of the organisation, usually in the form of an operational policy. Targets are set and monitored at strategic level and there are sanctions in place if these are unfulfilled. Thus at macro level documentation and quality frameworks legitimise the current role of the RNLD group, with the call for empowerment and increased competence of the client group.

Whilst at individual level, the RNLD implements activities based on person centred planning in order to change the behaviours of people with learning disability, which may distort communication and further disempower the marginalised group. Trent (1995 cited in Simpson,

1999) notes that the discourse of learning disability has been centred upon the person, because of technocratic as well as ethical reasons, with the opportunity for resource targeting as well as needs led provision. Aspis (1999, p.173) refers to the unequal power between professionals and people with learning disability observing that a closer examination might show how, "decisions are influenced by political decisions made by central government, which themselves are often based on dominant attitudes existing in society" (Aspis 1999, p.173).
Consequently, professional / client interaction is both restricting and restricted by the societal, policy and organisational forces in place, which may perpetuate the operation of a series of discursive practices.

3.4.6 The shift towards a healthcare model of practice

Equally the role of the RNLD as the professional with a specific knowledge of learning disability and the more recent emphasis on health care and health promotion, may also be shaped by a set of conflicting practices. For whilst the RNLD has established an ideological foundation based on normalisation, the division of health and social care, and the contested boundaries of professionals within it, has led to a renaissance of the nursing function within the RNLD group, and the focus upon empowerment in health care practice. Building on an evidenced lack of interest and knowledge in people with learning disability within primary care, (Prasher 1994, p.59, Stanley, 1998, p.23) and acute care, (Hart 1998, p. 471) community based RNLDs and those working in residential challenging behaviour units, have reclaimed specialist areas such as epilepsy management, control of diabetes, health promotion, and behavioural management with an underlying physical cause, which may be linked to a specific condition.

This shift into what was the sphere of medicine has been influenced by the emphasis on outcome based, healthcare practice for the RNLD endorsed in Signposts for Success (DOH, 1998), and the current governments proposals for clinical effectiveness for all professional intervention (DOH, 1998, DOH, 1999). The White Paper "Valuing People" (DOH, 2001) outlines a health facilitator role for community learning disability and learning disability nurses (DOH, 2001, p. 63).

For some practitioners the return to a nursing role has been a positive shift, (Parrish and Kay, 1998, p. 478) and there is a notable absence in the current professional literature of any challenge to the conflicting ideologies in place. For whilst some practitioners would challenge

any influence of the medical model, offering a nursing paradigm as a more accurate description of the RNLDs current activity, there is still limited coherence between the professions' stated value base of normalisation and the shift to a healthcare role in many areas of practice for the registered nurse.

3.5 The position of social work and broader practice issues

Jones (1998) writes that the history of social work has been marked by suspicion and hostility from the point of view of clients. Citing Wardman, (1977) he suggests that social work is one of the few services that has at no time been the subject of working class demands for expansion. Further he observes that at a time, when small sums of money were given to people, the monitoring of the process was "little different from the old system of poor law relief a hundred years ago"(Jones 1998, p.38). He argues that when racism is added to social work's underlying class hostility, then services are fraught with antagonisms (Jones 1998, p.39). Further many social work referrals come from a third party, rather than through self-referral, and remains one of those services that is associated with failure and stigma.

However Jones (1998, p.38) acknowledges the diversity of social work practice and concedes that not all clients are treated the same. This impacts on client experiences of social work, with some clients being seen as more deserving. Leading Jones to conclude that moral judgements about worth and deservedness still structure social work practice (Jones, 1998, p.39).

From the perspective of whom is seen as valued by the social work profession, the place of people with learning disability is of interest. Traditional social work, based on improving service delivery (Mayo,1998, p.166) has not situated people with learning disability as a priority group in welfare practice. McGrath (1991, p. 42) observes that "those with a mental handicap are frequently allocated to unqualified staff, and frequently regarded as a low priority group with much of the work, often inappropriately seen as 'maintenance' (McGrath 1991, p.42). Whilst Jones (1998, p.40) suggests that the profession of social work has always reflected rather than challenged prevailing social mores. The advent of deinstitutionalisation and the formalisation of social services as lead agency for this group of people may have created a more urgent need for action, although current qualifying education provides only limited opportunity for developing knowledge in the field.

Where social work led intervention with people with learning disability has been evaluated,

(Webb, Wistow, Vincent, Wray, 1991, p.508) the service development role has been the primary focus, with casework remaining secondary. This is in contrast to traditional social work practice, yet consistent with its contemporary values, centred on oppression as one of the major source of social problems. The more recent set of ideas focussed upon empowerment (Adams, 1990) participation (Biehal, 1993) and user involvement (Office of Public Management, 1994) form a more radical agenda for social work practice (Shardlow, 1998, p.31). Braye and Preston-Shoot (1995, p.48) offer the following definition of empowerment (cited in Shardlow, 1998, p.31):

- Extending one's own ability to take decisions, individuals, groups or communities taking control of their circumstances and achieving their own goals, thereby being able to work towards maximising the quality of their lives
- enabling people who are disempowered to have more control of their lives, to have a greater voice in institutions, service and situations which affect them, and to exercise power over someone else rather than being simply the recipients of exercised power
- Helping people to regain their own power (Braye and Preston-Shoot, 1995, p. 48).

However, some critics comment (Mullaly, 1997, p.31) that "There should be no presumption that the emergence of these new values or the development of older more traditional ones will lead to changes in professional practice" (Mullaly, 1997, p.31), for whilst as social work seems to be well placed to take on the likely issues of housing, poverty and employment with people who have learning disability, and their families in the community, the priority given to this group is likely to be low.

3.5.1 Social exclusion and Social Work practice

Becker's (2000) research into social exclusion, focusses on carers. One of the findings suggest that those who care continuously without a break, are likely to be vulnerable. As less than 8% of people with learning disability live independently, (DOH, 2000) and there is more than a 20,000 estimated shortfall of residential places, the majority of adults with learning disability live in the family home. This places additional pressures on carers. Equally the take up of benefits by this group is also reported as low (Ward, 2000). Whilst the introduction of payment for attendance at day centres by local authorities, albeit with the offer of wages for work done once present, has meant that many individuals are worse off (Mencap, 1999). The chances of increased poverty are high, and may be compounded by the inadequacies of the community

care assessment process for this group. Williams and Robinsons' (2000) research in the South West of England covered 5 local authorities. In seeking the impact of the Carers' act (1995) on families with a learning disability member, they found that of 157 carers eligible, only 22% had a needs assessment, and the outcomes were poor. One year later, 18 of the 42 services discussed were still not provided. Record keeping by professionals was also described as poor (Williams and Robinson, 2000). As one of Becker's suggested recommendations to create change, and reduce vulnerability to social exclusion is the implementation of a community care assessment, then the outlook seems bleak for people with learning disabilities.

Notably absent in the social work literature is any critical appraisal or campaigning against this lack of attention, by the social work profession, although as Symonds (1998, p.58) observes, the issues of poverty and learning disability has been addressed by sociologists. As social work, unlike nursing, has not fought for the position as crucial professional support, for this group of people, this should not be surprising, and it is likely to be at points of crisis, under statute, that social work intervention occurs. For example when adults with learning disability have children, social workers will have a statutory role in protecting their child. This creates a paradox in terms of rights and values, as parents with learning disability are at substantive risk of oppression by society as well as by professionals, in this context (Booth, 1994).

3.5.2 Spheres of Influence

Thus social work practice, crucial in the allocation of resources for people with learning disabilities, remains inconsistent for this group of people. Yet whilst the role of the RNLD is perceived by some stakeholders as critical it has often peripheral in the teamwork setting.

In seeking an explanation for this lack of autonomy, and subsequent team role, the position, role and knowledge base of the practitioner in the field of learning disability need further examination. Hugman (1991, p.95) cites Hughes, (1958) who suggests that an occupation that seeks to enhance its status should choose it's work carefully. He continues to observe that the status of work may be judged on the company kept. Therefore work may be considered "dirty" in two ways (Hugman, 1991, p.95). Firstly in a literal sense if it involves physical contact with human faeces, and secondly, in a metaphorical sense if the client group is of a low status. Thus a combination of the two may subscribe to a perception of a "polluting" low status client group (Hugman, 1991, p.95). In order to counteract this, groups such as nurses, need to minimise this routine side of work, and stress the glamorous elements. Attention should focus on advanced

technical skills. Howe (1986, p.30) writes that social workers are likely to emphasise the difficult case work in child protection, rather than time spent with an elderly person who has lost their pension book, and has nothing to eat in the house.
In the field of learning disability, this has been demonstrated in work with people who present challenges (Simpson, 2000, p.155).

Through this stress on complex work, caring professionals lay claim to levels of skills, which match forms of knowledge, aspiring to virtuoso roles (Davies, 1985). These roles have a set of significant characteristics, notably, they enable the practitioner to demonstrate skills and distinctive know how, they have autonomy and they produce measurable outcomes. Also significant is the social distance between the client and the professional, influenced by the occupational structures in place (Davies, 1985, p.33). Hugman (1991, p.96), emphasises the importance of these skills, in providing a "compelling logic" for the caring professions. They enable the building of careers and seniority in the agency hierarchy. This is perceived as important when the knowledge base of the professional group is disputed, or when there are sets of specific social problems for which the professional group has no solutions (Hugman, 1991, p. 96). Subsequently virtuoso roles (Davies, 1985, p.33) offer a "mediation between circumstantial practice and theoretical knowledge" (Hugman, 1991, p.96).
In his analysis, Davies (1985, p.33) separates virtuoso roles from caring roles, which have a lower social status and as Hugman observes it is these caring roles, that have been discarded by nursing and social work in the pursuit of professionalisation (Hugman, 1991, p. 97). Equally within the caring professions themselves, a set of specialist skills and knowledge have been identified as prestigious, along with a set of hierarchies of practice, based on the value of a specific group of clients (Hugman, 1991, p. 99). A client group with low status such as those with learning disability, lead to those professionals who support them having limited credentials, particularly as intervention is likely to be long term and supportive, rather than highly technical. This potential marginalisation of professionals and the ongoing struggle to achieve professional closure for nurses and social workers in the field, remains an issue as it has throughout the last two centuries. Ultimately it may begin to explain the restrictions on RNLDs in the teamwork setting. For committed teamwork to occur issues related to the status and contribution of teamwork members must have been addressed (Pritchard, 1995, p. 207). If team members are perceived as having limited expertise then their sphere of influence may be restricted. However the advent of the white paper "Valuing People" (DOH, 2001, p. 63)

offers the further development of the RNLD role as facilitator and advocate in the team work relationships of primary care.

3.5.3 Informed Practice

Parahoo et al (2000, p. 608) draw attention to the "lack of research providing the necessary evidence for practice in the field of learning disability in general, and learning disability in particular".Whilst Turnbull (1997, p.187) points out that a review of the contribution of the learning disability nurse has never been commissioned or published. Drawing attention to the lack of relevance of many high status research methodologies to the field, Parahoo writes, "Learning disability nursing involves human processes that do not lend themselves readily to investigations by randomised control trials (RCTs)" (Parahoo, Barr and McCaughan, 1997). Whilst noting the relevance of value of RCTs in some settings, Parahoo et al (2000, p. 608), suggest that other methodologies may be at least as appropriate, and the challenges for professionals are both to convince fund holders, and to involve people with learning disability themselves in the research design and process. A further challenge would be to motivate much of the RNLD profession to both apply and undertake research. In a survey, (Parahoo, Barr and McCaughan, 2000 p. 607), involving 87 nurses, (RNLD), RNMH), EN, plus RGN or RNM)) results indicated that more than one third did not see research as relevant to everyday practice, and that there was a lack of relevant research to utilise, within a largely unsupportive culture for research. Respondents were asked if they had implemented research findings in the two years prior to the study, and two thirds stated they had not.Whilst the study was undertaken in Northern Ireland, and amongst staff working in hospital settings, two further findings are of interest. Firstly that amongst those holding the Project 2000 RNLD qualification, (17 out of the 87) there was evidence that 47% had utilised research sometimes, and 52.9% had done so frequently (Parahoo *et al*, 2000, p. 609). This may indicate a more progressive practitioner profile for those holding a more academic based qualification, described as a "glimmer of hope" (Parahoo *et al*, 2000, p.609). Secondly, the levels of non-utilization of research, in this group of nurses in the field of learning disability, are higher than those holding the RGN qualification. Figures indicate that in a similiar study (Parahoo 1997) only 7.3% of RGNs, compared to the 19.5% of RN (LD or MH) stated that they seldom used nursing research.

In accepting that this is only one study, and as the researchers themselves note, less research evidence is available for this group to access, the findings reinforce the image of a

group at least in part, still victim of a custodial, attendant role past. Further, as research suggests, if this group is still seeking status in the interprofessional context of teamwork, then a lack of expertise and knowledge, based on evidence, may be as much of a barrier to effective practice, as the organisational and funding hierarchies of healthcare. Interestingly, Parahoo et al (2000, p.611) observe, that no amount of research can ensure that practice is evidence based, whilst suggesting that "the social, cultural, political and economic environment in which nursing is practised determine to a great extent its outcome" (Parahoo et al, 2000, p.611). Citing Parmenter (1991), they note that it is the study of history that will reveal the significant forces to influence service delivery.

3.5.4 The paradox of Practice

This analysis of professionals offering long term support in the field of learning disability demonstrates a series of conflicting ideologies and positions, mirroring their historical experiences. In the search for a specialist role, it is possible to chart the iterative nature of much of the progress made by the RNLD group. Episodes of legitimisation, such as the movements in the nineteen seventies and eighties, are interspersed with threats and usurpation. Equally history has demonstrated a lack of leadership for this group (Turnbull, 1999, p. 13).When professional roles and practice territory is examined, progress has been halting and increasingly narrow in focus, with emphasis on health care. Collectively there has been ongoing disagreement about the validity of models of practice, and there is evidence of the RNLD taking on roles which are perceived as low priority by other professional groups (Thornton, 1999, p.389).

A key role identified for the RNLD, is that of collaborator, (Kay *et al*, 1998), and yet research evidence available presents a series of restrictions placed on this group of professionals. Claims to specialism may indicate expertise in the field, and yet there is only minimal research based practice available.

What the RNLD group have consistently demonstrated, is durability throughout the decades. Their claim to be the only professional group to be this groups champion has had some political influence and maintained the qualification, despite falling recruits for the traditional RNLD in the last fifteen years.

3.6 A shift in priorities

Valuing People, the governmental review into Learning Disability services in England, the first of it's kind for thirty years, has been published (DOH, 2001) and is being operationalised. Key areas under review are children, family carers, supporting independence, health workforce planning and training and building partnerships. Together with the current expansion of qualifying social work training under the social care review, and the shortening of the foundation programme for nursing to one year, further changes in educational provision at both pre and post qualifying levels are likely. The complacency of the majority of social work agencies and primary care teams will be questioned. As Kinsey and Maguire (2001, p. 22) note, there will be three main areas to reward and penalise in regard to service quality: power and control in the development of advocacy services and more direct payment schemes, accountability in relation to partnerships within health and social services, with the possibility of a joined up approach to performance assessment, and within the workforce, the new learning disability award scheme which will take forward employer led accredited training along with a code of conduct for vocationally qualified staff.

Equally the position of the RNLD has been revisited. In the United Kingdom Central Council (UKCC) (now NMC, the Nursing and Midwifery Council) guidelines for nursing registration, there have been some moves toward the reintegration of the mental health and learning disability roles as yet unfulfilled. However other changes may occur when the UKCC becomes the Nursing and Midwifery council in April 2002 as apart of the government's review of professional regulation. Within the configuration of the primary care trusts locally, there has been some integration at least in terms of the planning process, between mental health and learning disability services. For service users in receipt of health care services (largely those labelled as having challenging behaviour, or requiring support in terms of sexual health, or with additional physical and mental health needs) the RNLD has still have a role to play. However for other service users in receipt of social care, the input of the RNLD is likely to be less formally supported in organisational terms with an increase in a vocationally qualified workforce.

3.7 At the practice inter-face

Following the broad shift in service provision for people with learning disability, two professional groups are largely responsible for the organisation and management of their long-

term support. The chapter has illustrated how these roles can be both ambiguous and at times contradictory. Social Work agencies remain lead professionals in terms of managing resources for care through the assessment process. However for many social workers or care managers, choosing to work directly and solely with people with learning disability is rarely an option, with residential care being undertaken in the private or voluntary sector by unqualified workers. On the other hand, the 21st century begins with the promotion of the RNLDs facilitation role within Valuing People (DOH, 2001, p.63), whereby the skills of the RNLD as advocate and change agent are at least in policy terms, formally recognised. Parrish (2001) quotes Nichols, who states that "It is imperative that the Learning Disabilities nurses' registered status is protected" and continues "the white paper will give the positive impetus that is needed to start to address the issue" (Nichols, 2001, p.12).

Chapter Four

Teamwork and Practice

In chapter two, a broad historical and contemporary review of health and social care policy and it's influence on interprofessional collaboration was discussed. In chapter three attention has focussed on people with learning disability and the key professional groups that offer longer term support, in a critical analysis of their current position at societal and service levels. In this chapter an analysis of research into interprofessional teamwork and learning disability practice will be presented. Outlining some of the complexities, contradictions and limitations of research undertaken, it is suggested that through positioning the individual's practice action within a narrow organisational context of teamwork practice, critical factors related to the structural and holistic frameworks of health and social care may be excluded. Consequently this may account for the limited development of any specific theories for practice in the learning disability field.

4.1 Researching teamwork

Moves toward the definition and application of different forms of teamwork, have both influenced and informed research in the field. A lack of theoretical underpinning for examining teamwork, has limited the breadth and depth of exploration. This is further compounded by a largely policy driven research agenda, which has resulted in problem focussed areas of study, whereby "a problem is identified and research contracted to guide requisite formation of policies" (Shipman, 1988, p. 166). Thus, methodological assumptions can also be identified (Hart and Bond, 1995, p. 63). These may be illustrated in the literature and research related to teamwork, which is predominantly centred upon the function of the primary health care team, excluding other areas of practice with a more limited concern for policy makers.

As a consequence, research into teamwork, like social policy has centred upon outcomes or ends. Stainton (1998 , p. 137) writes that the concern for policy makers, has been with numbers or bed spaces, and that whilst the ends may have changed, for example in learning disability from numbers of institutional beds to numbers of group home places , the focus on defining ends has not (Stainton, 1998, p.137). This emphasis on ends has impacted

on funding structures and mechanisms for service design and delivery (Stainton, 1998, p. 137), and parallels with research areas of interest and attention can be drawn.

Such factors have inevitably played a part in determining a criteria of inclusion, for this literature review, in that value has been placed by policy makers, on specific research and research outcomes discussed.

Some of the earlier definitions and discussion related to teamwork are presented due to their historical position in an emerging field of practice. In this sense, as published papers or books they have some external validity. Through the procedure of operationalising a concept, researchers and writers have attempted to achieve conceptual clarification (Merton, 1968, p, 168-171). In the case of teamwork, "the process of measurement, may lead to a refined definition of a concept, and bring about a greater degree of agreement with the empirical world"(Rose, 1982, p. 42). In contrast, some of the papers included here, by their very nature lack an explicit theoretical orientation (Rose, 1982, p. 101). As a newly emerging area of research, there may be limited comparability and precedent with other work in the field (Rose, 1982, p. 42). Once again, placing emphasis on the problem focussed nature of much of the literature.

Nakamura and Smallwood (1980, p. 31), in their discussion of policy research, discuss policy formulation. They observe that as policy formulation begins, there are a number of pressing questions. Initially these relate to the boundaries of the issue, the nature of information currently held, and the likelihood of change. They are concerned with "the ability of policy makers to define clearly and understand the problem or condition that they are facing" (Rist, RC, 1994, p. 548). The second area of concern considers previous attempts to both define and respond to the particular issue. Finally the previous knowledge gained is reviewed in order to consider current responses. Trade offs may be made, and as Rist (1994, p. 548) notes, there may be considerable pressure for short term solutions. In response to this policy makers often ignore "non pragmatic theoretical studies" (Rist, 1994, p. 548), and opt for that which is "in a form that enhances quick understanding." This approach has limited the development of theory and sets the boundaries for those bidding for research funding.

As a consequence the literature discussed reflects the constituent interest of policy makers and researchers. In turn this both ensures external validation of the research presented, in that it sits with the current body of research into the teamwork process, yet highlights the potential for a perpetuating and reductionist view of research in this field of practice,

particularly when the client group are people with learning disabilities. There are limitations in both the amount and scope of research undertaken in this area of practice.

The inclusion of smaller scale qualitative studies draws attention to the need to gain a greater understanding of the process and impact of change in the teamwork setting. However these are presented less often in the literature. Those included denote quality of observation in relation to the development of theoretical approaches to teamwork. As Scriven,(1972) notes, objective and subjective can be understood in a qualitative sense, in that this quality of observation stands regardless of the number of people making it. In the smaller teamwork studies presented, there is an emphasis on developing understanding, rather than through predicted testing. As Bryman, citing Finch(1986) observes, research is concerned with the process of implementation, rather than solely outputs. The attention given to a poststructuralist perspective, that is the linking of language, subjectivity, social organisation and power, (Richardson, 1994, p. 518) in the approach to teamwork, is an attempt to move beyond the current or normative response. The language of teamwork, and the lack of clarity around meaning, may be a symbol of the struggle that those operationalising teamwork processes face. As Richardson notes, "Because the individual is subject to multiple and competing discourses in many realms, one's subjectivity is shifting and contradictory, not stable, fixed and rigid" (1994, p. 518). Thus for individuals, meaning given, for example to teamwork, will be dependent on the different discourses available.

4.1.2 The complexities of definition

Jones, (1992, p. 27) suggests that it is difficult to actually judge different levels of teamwork, without some agreement on the characteristics and processes involved, in the practice setting. Opie (1997, p.260) draws attention to the anecdotal nature of much of the literature on teamwork. Reflecting upon current areas of research interest, she notes the organisational context of the content, notably, efficacy of health and social care teams, the problems with defining effective work and the extent of organisational resource required to enable effective team work (1997, p. 262).Quoting Youssef and Silverman (1992, p. 123), Opie acknowledges the influence of the organisational and policy environment in which both practice and research operate. Unpicking the 'appeal' of teamwork, by considering the meaning behind the rhetoric. For Loxley, the notion of teamwork, serves as a means or device to make a complex task more manageable. Drawing on organisational theory, Loxley suggests that such devices or symbols

are created to reduce confusion, resolve ambiguity and provide a sense of purpose or direction. In making a complex task more coherent, the appeal to teamwork cuts across professional boundaries and differences. By doing so, crucial issues with regard to power and competition are "fudged" (Loxley, 1997, p. 70). Consequently, policy makers are able to avoid structural issues and resource constraints, and present practitioners with the responsibility for making teams work. This means that "the myth serves to disguise the reality with an appealing ideology"(Loxley, 1997, p. 70).

Barnard (1987, p. 741) cites Halstead (1976), who observes the contradictory effect of policy documents and articles related to teamwork. "On one hand they have helped create a supportive climate to foster the growth of team care, but on the other hand, they have also created a false sense of legitimacy and effectiveness unwarranted by the facts." In making judgements about the position or weighting of research in the field of learning disability teamwork, an attempt to place the research both contextually, that is reflecting the emergent concerns and themes of a specific ideological and historical period, and context free, that is analytically has been made (Greenwood and Levin, 1998, p.103).Therefore both the concerns of the organisational or bureaucratic structures, and the competing emancipatory and professionalising agendas are explored.

4.2 Teamwork: Definitions and Perspectives

Teamwork in health and social care settings is a long established method of practice. Throughout its history, observers have noted both the rhetorical nature of it's application, along with a poorly defined description of its purpose (Evers, 1981, p.205). Yet the team remains the accepted mechanism for service delivery, and alternatives are rarely considered. (Halstead, 1976, p.507). Both definitions and descriptions of teamwork operate within a construct, where assumptions are made about health and health and social care. Further dominant values and ideologies have dictated the focus of teamwork and teamwork research. Loxley (1997, p.33), draws attention to the means by which models of practice are created as convenient devices in the organisation of the service. In her theses, Loxley argues that in order to work holistically, to meet people's needs, complexity and diversity have to be taken into account. In response a range of interventions both practical and rhetorical have attempted to make highly complex processes manageable (Loxley, 1997, p.33). Consequently this management of diversity means that professionals need to work together across health and

social care. Resulting in a scenario where " the absurdity of infinite self contained and self sufficient divisions of labour" (Loxley, 1997, p. 34) is acknowledged. A number of definitions of teamwork have been produced, for example Jones (1992, p. 27), Rubin and Breckhard (1972) and Gilmore et al (1974, p. 6) who define the team as : "A group of people who make different contributions to a common goal." Most writers, like Pritchard (1995, p. 206) have developed this definition into a series of characteristics, including the following:

- Team members sharing a common purpose which binds them together and guides their actions, along with a clear understanding of his or her functions
- An appreciation of the contribution of other professionals in the team, with a recognition of common interests and skills
- An acknowledgement that the team works through a pooling of knowledge, skills and resources and all members have shared responsibility for decisions made
- Effectiveness of the team is linked to it's capability to carry out it's work and to manage itself independently

Others may accept an organisational level definition of health and social care. Such definitions exclude the complex issues of society, and lack a consideration of the building of structures, managing of processes, and the knowledge that, "Working together, requires knowledge and education not only for responding to patients and clients, but also for relating to collateral members of the service network"(Loxley, 1997, p. 34).

Engel (1994, p. 65) offers the World Health Organisation definition of a team as a starting point, which begins to address the issues raised by Loxley;

> " A group who share a common health goal and common objectives, determined by community needs, to the achievement of which each member of the team contributes, in accordance with his or her competence and skill and in coordination with the function of others"(WHO, 1984, p.13).

Whilst Opie (1997, p. 262) acknowledges the need for a more holistic perspective in her description of the qualities of multi professional teamwork, noting : 1) The development of quality care for clients, through the collaboration of different disciplines, and the development

of joint initiatives. 2) The achievement of fuller more informed care plans, and therefore holistic care. 3) A higher level of productivity and professional satisfaction with subsequent more effective use of resources.

Lonsdale (1990, p. 1) notes the interdependency of structural, organisational and individual level systems, by identifying different categories of teamwork in four broad divisions. Between different helping professions, between professional and non professional workers and that of helpers in social services agencies and /or clients and communities. This description is underpinned by an expectation of practice centred upon the division of labour. Loxley (1997, p. 33) defines this division as a response to complexity and diversity , which because of differences in power and status, is not static. For in attempting to gain security, status and power, professions and agencies seek to capture new areas of practice, in competition with others (Loxley,1997, p. 33). As policy changes, then the focus of activity of groupings may also change. Additionally, levels of interdependence and interrelationships, shift and are reconfigured. In the field of learning disabilities, the impact of the purchaser / provider split of the 1990s (Greig, 2000, p. 26) has resulted in a redrawing of professional boundaries, as well as a questioning of the RNLDs effectiveness and accountability. As a consequence, the Community Learning Disability team may now be a single agency health team, involved only in specialist clinical provision, at the expense of CCA and care management, development work in accessing generic services, and service development and training (Greig, 2000, p. 27). The division of labour reflects changing levels of knowledge and advances in specialities, or new areas of practice. These emerging areas of practice are seen to be rational and have a purpose (Loxley, 1997, p. 33).Thus, health is a process of interaction for both individuals and populations.

This interaction is not reflected by other writers such as Webb and Hobdell, (1980, p. 97), who offer a typology of teams centred upon skills and tasks. They suggest that teams can be described in terms of the homogeneity and heterogeneity of skills and tasks. At the homogenous level this includes collegial and specialised collegial teams. One example being GPs working in a general practice or GPs working in a practice with some level of specialism, set within a hierarchy. The heterogeneous level is the place of the complex, multi disciplinary team whose members participate in a wide variety of tasks and hold a broad range of knowledge. The multi-disciplinary team can be defined as "teams where members, operating out of their own disciplinary bases, work parallel to each other, their primary objective being

coordination" (Opie, 1997, p. 262). In contrast, interdisciplinary teams are those whose members continue to work from particular disciplinary orientations, but undertake some joint collaborative work.

More radically, Leathard (1994, p. 9) describes transdisciplinary teams, where a high level of integration of roles is achieved, enabling a people centred rather than a organizationally structured system (Henwood, 1992). In this context, the complexity and diversity of practice and the division of labour have begun to be addressed. Other writers focussing on practice note that not all teams share this level of commitment. Bruce (1980) describes three levels of commitment: nominal, convenient and committed.

Nominal teamwork can be defined as "not really teamwork at all" (Pritchard, 1995, p.207) Examples of this form of teamwork are where professionals are attached to a group of professionals as a result of location or environment. Convenient teamwork tends to occur in teamwork settings where roles are delegated to others lower in the professional hierarchy. Committed teamwork is likely only where such issues as equality and status have been addressed, and team members can see and subscribe to the benefits that teamwork may bring. Ovretveit (1996, p. 163) has produced a detailed critique of teamwork, presenting five ways of describing and defining teams. He begins by noting that interprofessional work is much broader than teamwork, yet often it is the main way of organising and developing such work. In addition, there are many types of team with different forms of membership. The need for clarity in identifying the type of team, is important to Ovreveit, because: 1) practitioners need to understand the role of their team. 2) Managers may need to make changes which improve team coordination and service quality. 3) Planners will need to decide the type best suited to the needs of the client population. 4) Researchers will seek to contribute to knowledge about which type of team is most effective in a particular situation (1996, p. 163). Ovretveit's five definitions, are as follows:

- the degree of integration between professionals
- the extent of team management of resources
- the meaning of membership in the team
- the means by which clients experience the team, and who takes on which elements of practice

- the way in which the team is managed

In exploring integration, Ovretveit describes a continuum, from that of a loose knit voluntary association, where professionals are managed in their own professional group, to that of a closely integrated team where clinical decisions are framed within a collective multidisciplinary policy.

Looser teams may be described as networks, where practitioners work with a particular client group or come from the same geographical area. Dobson et al (2000, p. 25) describe such teams in learning disabilities, as "small fluid and temporal teams" (Dobson et al, 2000 p. 26). Each agency has separate policies, and procedures, and clients are likely to see different professionals at separate exit and entry points. In this form of network, meetings will be held to agree plans, and review progress. Formal links and referrals may be a part of the network activity. Full team integration is not possible where team members are employed by different agencies, and are still accountable to their employers (1996, p.164).

The second type of team membership described by Ovretveit, is one based on the extent of pooled accountability for resources. This form of shared responsibility does overlap with the level of integration within a team, although not totally. Ovretveit draws attention to the role of some closely integrated teams who are not responsible for serving a population. Equally there are loosely connected teams which are (1996, p. 166).

Within collective responsibility, the whole team must manage it's resources, and the team is financed as one unit. This raises issues in terms of the allocation of resources, and the determining of priority clients, alongside the individual, professional accountability. Conflict may result if these resources are scarce.

In terms of the individual professional, team membership is also significant (Ovretveit, 1996, p. 166). Membership can be both the foundation of good practice, and a source of tension in the team setting. In the early stages of team development, membership is not an issue. However when decision making becomes an element of the team's function, the extent of inclusion and exclusion in the process, determines membership. The position and role of individuals within the team may be questioned. In contrast, team membership may be historically determined. Ovretveit describes the teamwork situation in which members are present, not because of their specific expertise or skill, but because professional managers desire the presence of their particular profession.

Other areas of difficulty may be created through a teams inability to acknowledge the

difference in status or accountability of different team members. Ovretveit suggests three reasons for this: firstly, any recognition of difference may break a consensus of purpose of the team, particularly if it is fragile. Secondly, any reference to, or admission of different status, could be perceived as creating jealousy within the team. Finally, teams seeking more equal, participatory relationships with clients, may wish to have the same type of relationship within the team itself (1996, p. 168). Working with clients underpins Ovretveit's fourth definition. The ways in which team's refer, allocate and assess clients also differs. In addition time scales may also impact on team activity. Some teams have both long term and acute clients. Others work with only one group.

Lastly, the management and leadership of teams is an issue. Within the market led health and social care arena, professionals have worked within professional structures, up to general management level. Resources being allocated through a top down approach. At practice level professionals within their own professional group, have then allocated those resources. Ovretveit (1996, p. 169) draws attention to the limitations of this approach, in the team work setting, especially when interprofessional work is needed. Further, changes in the organisation of health and social care mean that joint working, along with moves toward joint financing, are more likely, with subsequent shifts in professional leadership.

In his analysis, Ouvreit like practitioners, is faced with a lack of theory on which to develop further his ideas. Research in the field of interprofessional teamwork is relatively new. A consequence being that innovators like Ovretveit, are largely drawing upon inductive, experientially based approaches to teamwork, in contrast to deductive or theory based critiques (Loxley, 1997, p.26). This observation is not intended to place greater status on deductive approaches. Its intention is to highlight the need for more repeated cycles of thought and action (Greenwood and Levin, 1998, p.55). The lack of research leads Loxley (1997, p. 25) to suggest that practice is based upon beliefs that remain implicit, rather than explicit, and because of this teamwork is in danger of being unexamined. Thus collaboration may be described not explored (Loxley, 1997, p. 25). Practice is then inhibited by a lack of dialogue, and any subsequent framework of ideas.

4.3 Teamwork roles in Learning Disability Services

In learning disability services, teamwork was both central to the policy makers agenda and a key area for research in the 1980s and 1990s. The creation of Community Mental Handicap

Teams (CMHTs), recommended by the interprofessional National Development Group for the Mentally Handicapped in 1976, meant that teams were to be specialist in focus with an expert based approach (Webb, Vincent, Wistow, Wray, 1991, p. 492). Team members would have a core membership of community nurses and social workers, with other recommended members. These were a consultant (learning disability), psychologist, physiotherapist, occupational therapist and speech therapist (McGrath, 1991, p. 16). The NDT stressed the need for local teams, along with the establishment of individualised packages of care, with identified key worker systems in place. Plank (1982) records a variety of composition of teams with most teams in 1981, having three or four members. These were usually a nurse and a social worker, with a psychologist and a consultant. Few teams had therapists or educationalists or health workers (McGrath, 1991, p. 16).Community learning disability teams still exist in the 21st century, albeit within a different policy context and agenda. Membership still remains mixed. Two recent reports "Facing the Facts" (DOH, 1999) and " From Words into Action"(NHSE and SSI, 1999), praise the impact of such teams, but their professional makeup is now likely to be single agency in the specialist health services (Greig, 2000, p. 27). Equally looser knit teams are still in existence. Despite this documented success, teams in the field of learning disability have shared the tensions of teamwork in other areas of practice. It is unlikely that the impact of Valuing People (DOH, 2001) will change this, with the RNLD largely focussing on carving out a clinical specialism, for example in dual diagnosis.

Interestingly there has been little research into teamwork in the residential setting in the learning disability field.

4.4 Two Decades of Teamwork in Learning Disabilities services

Early CMHT teams, which were piloted in Nottinghamshire between 1981 and 1989, were seen as pivotal in the planning of individual care packages and in the development of ideas about 'normalization' (Brown, 1992, p. 3).The Nottinghamshire study along with the overview of the All Wales Strategy CMHTs (McGrath, 1991)offer insights into the roles and function of teamwork, which remain relevant despite the changing context of practice.

The central task of the Nottinghamshire model was to provide different opportunities for clients and carers, based on new types of service provision (Webb, et al, 1991, p. 493). To achieve this, a development role rather than a case based role was seen as imperative. The focus on development rather than case work was controversial, with membership of the team

remaining predominantly social service rather than health care staff. As Webb et al note, by 1989, one of the health districts in the area had set up its own service of family support teams in order make sure that social work case input was available to families (Webb et al, 1991, p. 494).

There were few formal guidelines to support team objectives, and Webb comments ; "One of the key features of the Nottinghamshire initiative was that it occurred in somewhat of a policy vacuum" (Webb et al 1991, p. 495). There was no clear policy of care, and emphasis was on building new units of residential provision.

The aims of the Nottinghamshire project were: 1) To identify the needs of the client group, 2) to create and support alternative forms of accommodation, 3) to develop community support systems, 4) to act in a specialist advisory capacity to existing services (Webb et al 1991, p. 495). A seven year evaluative study was undertaken from 1981-1989, whose objectives were to monitor change in services in Nottinghamshire, and to evaluate the work of the CMHTs. Three issues were seen as important, firstly the extent to which teams maintained their space for developmental work, rather than be drawn into emergency case work. Secondly the effectiveness of teams in generating new services, and finally, the extent to which they mobilised community resources (Webb et al, 1991, p. 496). The outcomes of the research, which involved assessment of records, activity diaries, participant observation and interviews, offered insight into the practice of both social workers and nurses in the field.

The CMHT activities were divided by purpose over the 1984-1987 period. Results showed the amount of time available and given to casework, supporting services, administration, providing expert information, planning and creating services. In particular the extent to which teams had successfully maintained the no casework agenda was noted. Webb et al observe "the comparatively low level of traditional casework initially undertaken by the social work staff in teams and the substantial involvement in service development (Webb et al, 1991, p. 499). They note the contrast in the health service teams as being "an almost exact mirror image, they concentrated on a case work approach, although there is a slight hint of shift towards service development activities over time."

Equally outcomes in terms of service change and development were measured. Over the study, there were significant changes in the type and form of service provision on offer. Hostel type accommodation was replaced with warden aided schemes, unstaffed houses and the new adult placement service (Webb et al, 1991, p. 501). Whilst the size of units was

drastically reduced from forty to six places, on average. The Nottinghamshire project CMHTs were involved in the development of 163 places in 50 units between 1982 and 1988 (Webb et al, 1991, p. 501). Innovative schemes such as an adult placement service and a welfare rights programme with specialist advice provision also offered support. " Three hundred and sixty individuals and their families were helped during one year" (Webb et al, 1991, p. 507).

The social work situated CMHTs managed to maintain a developmental role through supportive activities. However the cost effectiveness of the approach is described as difficult to assess (Webb et al, 1991, p. 508). Comparisons are made in terms of workload and outcomes, notably the observation that "it required twenty or more social work staff plus three professional officers to develop the support services in Nottinghamshire". By comparison one of the health authorities would claim to have dehospitalised over one hundred patients with the help of one specialist developmental officer alone" (Webb et al, 1991, p. 508). However health care teams would have a range of other professionals and resources to draw on, and as Webb notes the health authorities and social services departments were engaged in different forms of service development despite a uniform ideal of community care.

4.4.1 Teamwork in Wales

In McGrath's (1991) study of CMHT team working, as a key element of implementation of the All Wales strategy, the overall research aims were: 1) To describe the role of the Welsh CMHTs in terms of size, composition, caseload and activities. 2) To explore how team members accommodated interprofessional differences, and how clear were professional roles, including progress made on care plans and key worker systems, as well as developmental work. 3) To explore the management and organisational context in which teams were operating and their impact on teamwork. 4) To assess the achievements of teams and what factors hindered or encouraged their effectiveness (McGrath, 1991, p. 10). Of the 37 CMHTs in Wales, the researchers covered 31 teams, in 1987, with 6 teams in Clwyd having been reviewed in 1986 (McGrath and Humphreys, 1986). Fieldwork consisted of questionnaires, team interviews and interviews with senior or middle managers (McGrath, 1991, p.10). The research into teams took place in the middle of the All Wales Strategy for the Development of Services for Mentally Handicapped People (Welsh Office, 1983). This strategy placed the needs of people with learning disability within a comprehensive service framework. The AWS had several strengths. Hunter and Wistow (1986) note the central and singular departmental

structure as opposed to the three separate divisions in England, between the DHSS, the DOE and the Treasury (McGrath, 1991, p.17). Equally the additional funding allocated centrally to this group of people. Funding was not allocated to developments if evidence of inter-agency cooperation, and carer participation were not in place (McGrath, 1991, p.17). Also of significance was the coterminous nature of all but one of the health and social care boundaries in Wales at the time (McGrath, 1991, p. 18).

The McGrath study explored the commitment to team work of the CMHT members. More than half the teams identified commitment to the AWS and their role as significant (McGrath, 1991 p.59). Other teams were finding it more difficult, but only a very small minority cited the joint working element of team function as a negative feature (McGrath, 1991, p.60). In relation to professional roles, the majority of teams had a good knowledge of the roles of other team members, and established positive working relationships. In some teams a blurring of roles took place, and McGrath records that this was most common between social workers and community nurses (McGrath,1991, p.62). She continues " given the background of these two professional groups and the potential for overlap in their tasks, it can be hypothesised that either marked professional territoriality disagreements will remain a feature, or considerable blurring of roles will occur (McGrath, 1991, p.62). Two factors contributed to this overlap. Firstly the number of nurses undertaking counselling courses, whilst key social work functions such as child care or mental health legislation, were carried out by members of generic social work teams.

4.4.2 Interprofessional Differences

A key factor in relation to practice in the interagency context, was interprofessional difference. One constraint identified (McGrath, 1991, p. 62), was disagreement at senior manager level about the role of the nurse, within the team. Equally, teams did not have autonomy in the referral process. Systematic ways of working or reflecting on workload were absent (McGrath, 1991,p. 63). This experience has some parallels with the Nottingham project (Webb et al, 1991, p. 508), in relation to the role of the nurse, whilst in primary care, West and Poulton (1997, p.205) document the lack of attention to team objectives by the primary health care team.

A further research aim was a review of the progress made by the teams in the area of care planning or Individual Programme Planning (IPPs). A key target of the AWS was a needs led service, with IPPs being the pivot for this. All clients were to have one as stated in county

objectives (McGrath, 1991, p. 69). Progress was slow and only 5 teams reported having set in place plans for 25% or more of their clients (McGrath, 1991, p .69). A set of criticisms of the process were recorded, notably dissatisfaction with the IPP tool, the time taken to complete the documentation, and the emphasis on professional need rather than client need (McGrath, 1991, p . 69). Interprofessional conflict was noted with the views of the most senior or highest status professional overriding others (McGrath, 1991, p. 68). Once again similarities with team work in primary care are present (Hiscock and Pearson, 1996, p. 30), whilst the powerless position of the client and their family is highlighted. The complexities of taking on the driving key worker role was also an issue, with professionals perceived as giving less time to the coordinating work, and non professionals having diminished legitimacy (McGrath, 1991 p. 76).

In terms of team priorities IPPs did not take precedence, with more than 25% of the teams responding to demand. Additionally priority setting was ad hoc for many teams. Some had targeted specific groups of people, for example those with severe learning difficulty, which was seen as costly in terms of resources. McGrath (1991, p. 82) records the controversy this had created, and its' impact on progress within the AWS. Progress was slower because of the complex needs and services of this group. Conversely, working with more able people was viewed by some of the teams as a better way of getting the AWS off to a good start.

A small scale, local research study , based on a survey in Southern England (Aylott, Toocarum, 1996, p, 492), reviewing service user and carer expectations of multidisciplinary learning disability teams, suggests that people with a mild learning disability are more likely to receive a multidisciplinary service, than carers who are supporting a person with more profound severe learning disability. Like the earlier McGrath study (1991, p. 76) the issue of resources and type of intervention were an issue.

4.4.3 Interprofessional Relationships

Development work in terms of building on community networks, and designing alternative service options, was given a new dimension as part of the AWS (McGrath,1991, p.97). Professionals described an expansion of their roles, in particular social workers and nurses. The role of Community Learning Disability Nurses, (CLDs) as in the Nottingham project, was that of working with individuals and parents' groups, rather than broader service development. Social workers were likely to lead on community development in 40 % of the teams (McGrath, 1991, p. 104). Whilst the issue of status in relation to the negotiating roles involved is noted

by a small number of teams (McGrath, 1991, p. 107). The position of team members, with regard to status is also picked up in a discussion of the extent of co-ordinated services, a crucial aim of the AWS. McGrath writes that it was not possible to assess the effectiveness of liaison with other professionals, outside the teams, however assessment processes meant that interprofessional collaboration was vital. Relationships with staff involved in other aspects of provision, such as day care were sometimes difficult, largely because of differing philosophies of care (McGrath, 1991, p. 131). Links between area social work teams, and the CMHTs, were also problematic, with the area team's emphasis on crisis work only, being viewed as a limitation One area officer, notes "when the chips are down, mental handicap has a low priority".

Additionally, the generic teams were unaware of the development work being carried out by the CMHTs, and there were expressions of loss of control from them.The emphasis placed on people with learning disability and their families, by the AWS, increased expectations of the generic teams, yet they felt their role was eroded. A lack of involvement in planning and processes beyond referral was described (McGrath,1991, p.133). More positively the overall response to learning disability was viewed as more optimistic.

Relationships with other professionals were mixed, depending on the relationships with senior managers. Good practice level collaboration was sometimes not endorsed, notably in education, child health and the therapy departments. Paediatricians were least likely to refer on families across the whole of the study area, described by those in the CMHTs as professional protectiveness or territoriality (McGrath, 1991, p. 136). Interprofessional collaboration was discouraged by administrative as well as professional barriers.

Good examples of liaison were developed through formal guidelines, development type forums, commitment of key professionals, and an opportunistic approach. In terms of management of the teams, the position of the learning disability nurses was an issue, with dual accountability to the team and their nursing manager creating a lack of support. Health was seen as very hierarchal (McGrath,1991, p, 163) , with a documented overriding of decisions made by nurses in CMHTs, by health authority mangers. Some teams and mangers did change over time, but where strict control was kept on nursing activity it was reported as very problematic.

Overall the CMHTs also had some problems with accountability, and the management support of some teams was uncommitted and nebulous. McGrath writes that an "extensive gap

in understanding and trust was apparent" (McGrath, 1991, p . 170). McGrath's findings suggest a refocusing on communication, clarity of objectives, and a system put in place to ensure problems are acted upon by senior managers. She also recommends a inter-agency group to address operational interprofessional and inter-agency matters (McGrath, 1991, p, 173).

4.5 Questions for Learning Disabilities Practice

The detailed examination of teamwork roles, relationships and responses offered by McGrath offers evidence of practices that once uncovered, raise a series of further questions for interprofessional research in the field of learning disability. Notably the position of the nurse and other professionals, in the CMHT. To what extent is committed multi agency teamwork (Pritchard, 1995, p. 207) possible for this group? Whilst Wistow's earlier Nottingham study (Webb et al, 1991, p.508), illustrates a restricted role for the nurse, the influence of the health authority was reported in more muted style, and the influence of the hierarchy, in health is less apparent than in the Welsh study.

Whilst the two studies are different, it is an interesting fact that in them both, it appears that participating RNLD nurses are less able to practice in more creative and autonomous ways, than other professionals. Significantly a decade later, there is a suggestion of further insularity of this group of practitioners who are working in health only CLDTs (Grieg, 2000, p. 27). The ability of CNLDs to practice reflexively in teams remains at issue. And whilst CNLDs are operating in less traditionally hierarchal teams, than other community nurses in primary care, their sphere of influence in terms of developmental work, may still be restricted.

Secondly how can effective teamwork be measured? The needs of the individual person with learning disability and their family may be in conflict with the broader aspirations and goals of professionals. Equally the measurement of outcomes can be problematic, when teamwork with marginalised people is explored. The value placed on a particular group of people and its impact on teamwork may also require further investigation. There remains limited research into some elements of teamwork practice in the learning disability field, ultimately reflecting the dominant cultural values of society and the low priority given by governmental policy makers to this group.

4.6 Teamwork literature: Drawing Conclusions

In this analysis of research into teamwork, a divergent series of contexts, definitions and

interpretations of teamwork has been noted. Through pursuing some elements of teamwork research further, a broader examination of the literature in health and social care has been undertaken. Whilst this indicates an absence of specific research in the field of learning disabilities, comparisons may be drawn in relation to the practice contexts analysed. As Glaser and Strauss (1967, p. 167) note, data in some areas can be thin, and the scanning of literature which represents other groups or has more remote ties to the area of scrutiny may be productive.

Many of the research studies are concerned with organisational structures, and their impact upon the teamwork process. There is limited evidence of attempts to define the context and nature of health and social care, in which team work operates, and what this might mean in everyday practice terms. In this sense, the external view, that of the researcher, seems to be concerned with the same organisational or internal agenda as the research participants. In many cases there seems to be an omission of the "outsiders"view point, that "discovery of the unexpected, and counterintuitive explanations, often hidden from view by assumptions" (Greenwood and Levin 1998, p. 99). Thus the internal cultural paradigm, that is the means by which, an organisation creates a relatively homogenous approach to the complexity it faces, (Johnson and Scholes, 1997) seems to be accepted by the external researchers.

Whilst Greenwood and Levin are referring to action research, they make an observation which has a wider resonance for research in the teamwork setting. They note that the researcher brings a set of analytical frameworks to the research process, which includes views on the political economy, social structure and change process and ideology. Greenwood and Levin note the importance of this knowledge, as these analytical frameworks are important to the conceptualisation of the relationships between past and possible futures (Greenwood and Levin, 1998, p. 99). Equally other work in the social sciences has developed perspectives and methods which can make such structures clear.

The organisational and practice level focus of research into teamwork, in many cases excludes such conceptualisation. There seems to be an acceptance of the concept of healthcare, a perception that it is a static environment. The place of human beings within it, either as team members or service users in health care may be viewed as reductionist. Loxley (1997, p. 79) describes this as the "nothing but entity, the fractured femur in the third bed, the inadequate mother..." The labels "carer of a person with profound disability", or "social worker as team resource holder" could equally apply.

In highlighting the similar position of the researcher and the researched, the intention is not intended to question mutualism (Greenwood and Levin, 1998, p .77), in the research process. Rather it is to challenge the narrow organisational perspective of much of the research into teamwork. In the literature available, as Loxley observes, (1997, p. 25) knowledge related to teamwork practice remains implicit rather than explicit.Thus, practitioners are frustrated in their attempts to take practice forward. Further, research knowledge gained "has to aim at the solution of problems", and "the knowledge produced by the enquiry process must increase participants control over their own situation (Greenwood and Levin, 1998, p. 77). As Greenwood and Levin note, this approach is consistent with that of Freire's (1970) concept of conscientization, within which the process of inquiry is aimed at shaping knowledge, building on a critical understanding of the historical and political contexts within which the participants of research act (Greenwood and Levin,1998, p. 77).Through this process participants must be able to use and apply knowledge, and it must support the participant's goals (Greenwood and Levin, 1998, p.77).

In this review of teamwork literature and research, the limitations of some definitions and studies, and the sparsity of work in some fields, has in many cases let down potential participants and practitioners. The lack of diversity, may limit creativity, (Loxley, 1998, p. 25) and the focus on practical problems not the nature of practice, in teamwork settings, ignores the complexity of the systems in which teamwork exists.

4.7 Strategies for interprofessional practice

Having set out some concerns in relation to the focus of team work and interprofessional research in the field of learning disability, there is a need to gain a more detailed understanding of how practitioners view practice. The next chapter and phase of the research will take this forward, exploring practitioner experience and strategies for teamwork. Central to gaining an understanding will be the nature and use of power and how practitioners develop an awareness of empowering and dis-empowering qualities in their everyday work.

Chapter Five

Key Elements in the Research Process

As a practitioner in the field of learning disabilities I have experienced at first hand many of the shifts in ideology, policy changes and the re-evaluation of professional / service user roles and relationships explored in chapters one to four This experience has also shown that there was a relatively small formal literature or research to draw upon in relation to the long term support of people with learning disabilities.

The sparsity of both informal, substantive and formal theory for practice was not reflected in the quality of informal or experiential practice knowledge that I had seen. Therefore my research methodology was founded on a desire to capture the views of learning disability practitioners in the interprofessional practice setting, drawing on their personal theories for practice and their responses to the context of care. However on my route toward achieving this I had to work through a series of personal barriers about the nature of research and the role of the researcher, before I could begin to make progress. The use of the general principles of grounded theory methodology have facilitated this process.

5.1 Stage One : The Start Of The Research Journey

5.1.1 The new world of research

At the start of this research I owned a different set of beliefs and assumptions about the nature of research and the role of the researcher. On the journey I was to discover that these beliefs were both liberating and oppressing and on reflection, at no stage was this personal dissonance more apparent then at the beginning of the field work. Straight from the dizzying heights of the methodology programme, I was both exhilarated and terrified. Research seemed a world away from practice with its uncertainty, (Powell, 2001) ambiguity and shifting outcomes. This perception was to be the first in a series of personal barriers which initially prevented me from making progress. Research seemed to be concerned with measuring, objectivity and separation from the real world,.whilst my practice experiences told a different story in terms of the nature of peoples lives and experiences and what might be meaningful to explore. My thinking led me to the research literature and in particular grounded theory methodologies. This reading made me realise that research could be a part of the world of practice, with both the

potential to develop theory and ensure that the participants voices were heard. Feeling more comfortable, I set about overcoming the next barrier which concerned my position as a researcher. I viewed myself as a lecturer in learning disabilities with a background in nursing. In this role I was confident and knowledgeable, and able to draw on experience. As a researcher I was a novice, with my previous experience centred on disseminating the research findings of others. However whilst reflecting on my position I decided that in order to move my practice forward I needed to undertake my own research. I felt that only through participating in the research process itself could I grow as a practitioner and further develop my values, belief and knowledge. With this in mind I attempted to embrace this new world and set out on the tentative first steps. However these were not to be linear but iterative in nature, with events happening simultaneously and from different methodological perspectives, particularly at my starting point. For even as my reading on qualitative methods had inspired me, I was also mapping out a semi-structured questionnaire. In retrospect I believe this somewhat dissonant approach was a very necessary part of the research, journey, however at the time I was overwhelmingly concerned with 'doing the research in the right way' and seeking some control over the processes involved.

Ultimately a fusion of early ideas was to be consolidated in the use of the guiding principles of grounded theory. This gave me the confidence to accept that my thinking about research was not incorrect, rather it was a integral part of the research process itself as I began to generate data. Inspired by the space in the approach for inter- subjectivity I proceeded. My first steps are presented in a linear format, despite them occurring simultaneously.

5.2 Grounded Theory Methodology

Grounded theory is described by Glaser and Strauss (1967, p.1) as 'the discovery of theory from data' and more recently by Strauss and Corbin (1994, p. 273) as a 'general methodology for developing theory that is grounded in data systematically gathered and analysed'. Alvesson and Skoldberg (2000, p.12) note that the inspiration for grounded theory came from the symbolic interactionism movement developed by Blumer in Chicago in the 1930s.However whilst they acknowledge central features of symbolic interactionism within grounded theory, they stress that these features have not been automatically transferred to it (Alvesson and Skoldberg, 2000, p.13). Briefly these features include pragmatism where meaning or the truth is viewed only in relation to reality or to practical features. People therefore act and interact

based on the meanings that a particular interaction has for them and those individuals they encounter (Blumer, 1969, p.2). There is no fixed meaning and meanings and interactions are constantly evolving (Dey,1999, p.26). Meaning is explored within micro-processes, rather than macro- structures. Social interaction is central and related to inter-subjectivity rather than external factors in the spirit of behaviourism. In terms of research approaches these are founded on ideopathic or particular cases where intensive study of unique phenomena occurs in contrast to ideographic research which is dominated by large amounts of data and the discovery of general laws (Alvesson and Skoldberg, 2000, p.14). The explorative function is key with emphasis on flexible data collection and intensive scrutiny and revision of original concepts (Alvesson and Skoldberg, 2000,p.14). Cognitive symbols are significant and the self is a part of the research process. As Alvesson and Skoldberg(2000, p.14) affirm, the self is the engine of the entire social process. Equally, sensitising concepts are created to offer alternative dimensions of the world. Blumer (1954) describes the use of sensitising concepts as guiding research through direct study of the social world. Unlike the creation of definitive concepts where research processes ensure the abstraction of data from the social setting and the use of standardised techniques in their generation, data is not extracted from the social world. Instead sensitising concepts are less specific ideas about a phenomenon and may include the researcher's judgements or thinking about the other persons' position. From this position alternative meanings and vocabulary may offer the researcher opportunities to refine and improve concepts. Further whilst in other research approaches the context surrounds the research, in the grounded theory approach, structural conditions are intrinsic and central to the situation. Thus researchers are encouraged to remain close to the everyday reality and not put too much distance between themselves and the data (Alvesson and Skoldberg, 2000, p.14). Consequently, qualitative research methods are of major importance (Alvesson and Skoldberg, 2000, p.14).

In the use of a grounded theory approach, emphasis is placed on theory generation rather than verification. Glaser and Strauss (1967) note that far too much emphasis has been placed on verifying existing data when the focus should be on discovering theory. Verification can be used to serve generation. If existing theories seem appropriate, these can be elaborated and modified as incoming data are meticulously played against them (Strauss and Corbin, 1994, p.273).

Theory is described as 'plausible relationships proposed among concepts and sets of

concepts' (Strauss and Corbin, 1994, p.273) and where concepts are a coherent set of general propositions used provisionally to explain a phenomenon (Stein and Urdang, 1981 p. 1471). In seeking relationships between concepts, grounded theory presents these relationships in both thick description and in conceptual writing (Glaser and Strauss, 1967, p.31-32). Grounded theory facilitates the capturing of relationships between concepts and consequently the outcomes of changing interactions or conditions. Emphasis is on the coding process whereby categories are developed from the data (Alvesson and Skoldberg, 2000, p.24). This is followed by the continual comparison of newly coded data with data previously coded in the same category. This takes place until saturation occurs and additional analysis no longer adds anything new to the category (Alvesson and Skoldberg, 2000, p.24).

Three factors are critical in the development of theory. Firstly, the use of memos on the theoretical ideas that arise during coding and in the connection between category properties. These may be discursive, asking questions and seeking answers from the data whereby, theory gradually emerges. Secondly, a core category is identified around which all others revolve. This is crucial to gaining the key to the theory (Alvesson and Skoldberg, 2000, p.28). Critical elements of this core category are identified by Strauss (1987, p. 36). It must be central and related to as many other categories as possible. It should also feature more frequently in the data. Connections between the core category and other categories should be plentiful. The core category should have implications for theory development. Finally, diagrams are used to illustrate how categories relate to one another. These can be simple or complex but should show how the categories or concepts hang together (Strauss 1987, cited in Alvesson and Skoldberg, 2000, p.29).

Through the process of integrating the categories or concepts, theory is integrated and is developed as a natural part of the research process. The nature of this theory may be substantive or formal. Glaser and Strauss (1967, p.32) suggest that substantive theory is used to develop a substantive or empirical area such as patient care, whilst formal theory is more abstract and develops a conceptual area, for example social mobility. Alvesson and Skoldberg (2000, p. 31) suggest that these boundaries are fluid and that levels of generality are also at issue. For example a study of professional loss in care of dying people could be generalised at a higher level to study loss in wider society.

5.3 Factors Influencing Choice of Methodology

Other practice related factors were also to be influential in my decision making. As a

practitioner in the learning disability my major concern was the lack of substantive or formal theory to draw upon in relation to interprofessional practice. A great deal of time has been spent in determining the practice role of nurses and social workers in the long term support of people with learning disabilities (See chapter 3). But the field remains under researched. Therefore grounded theories emphasis on developing substantive theory which could then be further explored was very appealing.

5.3.1 A focus on micro-processes

Those observers who argue that such research with its focus on a "lower level" of generality, might not lead to anything new or interesting have failed to appreciate the strengths of the methodology. The very nature of grounded theory provides the practitioner with space to look at micro-processes and subsequently to present theory to explain them. For myself, discovering how practitioners articulate strategies for change at practice level, offered the opportunity to capture thinking in a conceptual model, which may in future be further developed at a higher level of generality and thus provide an even more sophisticated understanding of practice.

Before then there was a pressing need to examine more closely the realities of practice, placing them under scrutiny and capturing solutions to barriers in the interprofessional context. The principles of grounded theory meant that research findings generated are often immediately accessible to practitioners themselves, either in the form of practical application or in gaining an increased understanding of a phenomenon. The closeness of the data to the theory generated creates the conditions for this to happen.

A further strength of the grounded theory approach is that this closeness does not stifle new ways of thinking about practice or a subjective interpretation of the data. This is because the researcher is enabled to take a 'minute examination' of the data and categories, whilst keeping close to the everyday and the concrete. Thus data are shifted around in the researcher's mind in every possible way (Strauss, 1987, p.33). The transparency of the coding and conceptual development process ensures that for each step taken, the questions raised by the researcher and asked of the data are visible, making the researcher's interpretation and analysis explicit.

5.3.2 Connections with practice

Equally the theory must work, being able to "fit the situation being researched, and work when

put into use" (Glaser and Strauss, 1967, p. 3). Not only must the theory generated make sense, it must also be able to make links between the concepts and their relevance for the clinical setting. Morse (1997, p.183) has suggested that the researcher must bear some of the responsibility for this by making recommendations for practice. Grounded theory methodology with its emphasis on the fit of data, that is a good representation of the phenomena or concept being presented (Morse, 1997, p.168) with categories (Glaser, 1978) ensures that the ambiguities of practice cannot be overlooked or omitted but must be integral and explained through the systematic definition and description of concepts. This factor is a critical one when undertaking research that aims to be both credible and practicable.

5.3.3 Responsiveness to changing conditions

A further strength of grounded theory, again linked to the realities of practice, is the criterion that theory should enable the practitioner to have " partial control over the structure and process of daily situations as they change over time" (Glaser and Strauss, 1967, p.237). Because the generation of categories is provisional and theory production is conceptually dense, it is sensitive to the changing conditions under which it can be applied (Dey, 1999 p.233). A grounded theory approach offered the room for adjustment as part of the concept building itself, preventing the generation of any static or rigid frameworks which would be time limited.

5.4 Research and Reality

Having decided on a broad area of research interest, I then had to begin the research process. Already tension was present as I attempted to balance my personal belief in general qualitative research principles with a fear of drifting aimlessly into the unfamiliar area of practice that was research. As described in section 5.1.1, I eventually decided that my fears would only be minimised if I took practical action, and having confronted my personal barriers in relation to the nature of research and my novice status I began. The development of a semi-structured questionnaire was my starting point. This offered structure and met my aims in relation to developing a greater understanding of practitioners' views. Also present was a personal feeling of 'lets see what happens ...'.

5.4.1 The semi-structured questionnaire

The semi-structured questionnaire (See Appendix A1) had several purposes, initially to provide a systematic starting point for the research, using the literature on interprofessional practice. It began the process of answering the broad research question 'How professionals in the field of learning disabilities view interprofessional practice?'. Clark and Causer (1991, p.167) note that all researchers need to identify the key concepts in their research. "The need to show awareness of and to examine critically, the most important definitions and concepts in the existing literature...will need to be worked on throughout a thesis." The use of the literature on interprofessional practice, both underpinned the questionnaire design, and ensured that the areas identified by the researcher could be used to "benchmark existing areas of knowledge" (Clark and Causer,1991, p. 167).

The questionnaire design was straightforward, and it was only on application that personal and intellectual tensions returned.

5.5 Questionnaire Design

The development of the questionnaire was undertaken in order to begin to address the research question, 'How professionals in the field of learning disability view interprofessional practice'. It was designed to capture both theoretical thinking and offer a framework to ground subsequent interview themes. In constructing the questionnaire four main response areas were focussed upon. These were behaviour, beliefs, attitudes and attributes (Dillman, 1978, p.80). De Vaus (1994, p.82) describes questions related to behaviour in terms of what people do, in other words, where the participant is working, and in what role. Additionally to describe the teamwork setting, ie health and social care in which the person is situated. When seeking information on individual beliefs, the questionnaire centres upon the individual's interpretation of interprofessional practice. De Vaus describes such questions as establishing what people think is true, rather than the accuracy of beliefs (1994, p. 82). In this context the use of definitions of interprofessional practice have been used to elicit individual belief. In attitudinal type questions, the researcher is seeking responses on participants' experience of interprofessional work. Within these responses participants may seek to give an ideal answer, rather than a reflection of the reality of interprofessional practice. For example client need may be seen as the most desirable goal of interprofessional practice , and stated first, even if not always achieved. Lastly, attribute questions relate to questions about the respondents'

characteristics (De Vaus, 1994 , p . 82). These include information related to organisational roles, and management structures.

Each question was formulated to take into account the need for clear and unambiguous questions (De Vaus, 1994, p. 83). The language used was appropriate for the audience participating. Two questions were closed, with one question having four previously determined answers. In the adaption of this form of closed question, the criticisms of forced choice questions were noted, whereby "They can create false opinions either by giving an insufficient range of alternatives from which to choose, or by prompting people with acceptable answers" (De Vaus, 1994, p. 86). The use of the two closed questions as the starting point for participants, had two functions. One was to see if individuals had thought in advance (Gallup, 1947) about the issue of interprofessional practice. The second was to encourage participants who might be less fluent in writing responses (De Vaus, 1994, p.87). A further closed question elicited basic information related to professional role. As Glastonbury and MacKean (1991, p.238) note, questionnaires should start at a fairly routine level, moving gently into the harder or more personal ones. All remaining questions were open ended, in which participants formulated their own answers (De Vaus, 1994, p.85).

The questionnaire was divided into two sections, one related to individual views on interprofessional practice, and the second focussed on issues for practice intervention. Each category was developed from key themes in the literature.

Interprofessional Practice Questionnaire Themes	
Individual	**Practice**
Definition of Interprofessional Work	Everyday practice and Interprofessional Work
Job description, Element of Interprofessional Practice.	Organisational Support
Client Focus-Helped or hindered by Interprofessional work	Elements of Interprofessional work disliked
Time given to Interprofessional practice in professional preparation	Managers demonstration of Interprofessional Work

Three key elements of Interprofessional work	Place of Interprofessional practice in formal supervision
	Organisational goals and Mission Statement
	Physical Environment of Practice
	Professional Backgrounds of Colleagues and Impact on Interprofessional work

Figure 1 *Questionnaire themes*

5.6 The Sample

The semi-structured questionnaire (See appendix A1) was forwarded to a sample of eighteen respondents. Criteria for inclusion were; undertaking their professional education at the same institution, and qualifying in the previous two years. In addition all were working with, or had responsibility for, people with learning disability in their current practice. The respondents held either an RNLD, a DipSW, or were jointly qualified as RNLD/ DipSW. There were six respondents with each qualification.

The sample were all participants who were known to the researcher as former students, and all had studied the Learning Disability pathway, a theoretical unit of study offered as part of the DipSW, and the RNLD/DipSW programme. For the RNLD and DipSW groups, this relationship was that of contact through the classroom setting only. In other words the researcher had taught the group members as part of her professional role.

For the jointly qualified group, the relationship was more constant, as the researcher had been involved in the design and development of the educational programme the students were experiencing. Supervision of practice did not take place for any of the research participants. Age, gender or race of respondents were not criteria for inclusion or exclusion.

Traditionally, in the use of the questionnaire as a research tool, researcher contact with the respondents may be minimal (Bryman, 1996, p.95). When they completed and returned this questionnaire (see appendix 2 for examples), the researcher had no personal contact with the respondents. At this stage of the research, professional contact was limited and differed from that of the relationship in the next stage, where there was "a strong urge to get close" to the participants (Bryman, 1996, p.96).

Nevertheless, a previous link with a third of this group raised issues in regard to the moral and social obligations presented. As Punch (1994, p.88) observes, the move toward a

partnership role with research respondents, is set within a paradigm based on an avoidance of harm, consent and confidentiality. All of the questionnaire respondents were formally invited in writing to participate. Details of confidentiality processes were provided, along with a clear statement related to the research aims, purpose and likely outcome. As Bulmer writes, "Identities, locations, of individuals and places are concealed in published results, data collected are held in anonymized form and all data is kept securely confidential" (1982, p. 225). From this position, it was assumed that respondents who returned questionnaires had given consent to be involved in the research study. Equally, as the questionnaire was completed in the absence of the researcher, the charge of moral obligation on the part of research respondents to take part in this study, are negated. From a sample of 18 respondents, who were forwarded a questionnaire, a response rate of 100% was achieved.

5.7 The approach

In research design, questionnaires would normally constitute an element of the survey method in the social sciences. The survey is described by Bryman (1996, p.12) as "the main vehicle of quantitative research". Erlandson et al (1993, p.36) in their debate concerning methods, note that "researchers will sometimes use quantitative methods as a preliminary tool to obtain a quick picture of typical and atypical cases". However this remains less common than a qualitative approach preceding a quantitative investigation (Bryman, 1996, p.136).

The small number of people holding the dual qualification nationally, and locally, placed a limit on an available sample size. When stage one of the research was undertaken, only one other higher education institution, beside the one in which I worked, offered the joint qualification in nursing and social work. Both institutions had closely aligned curricula in order to meet the requirements of the two professional bodies, which validated the programmes, the English National Board (ENB) and the Central Council for Education and Training in Social Work (CCETSW). The available number of professionals holding the RNLD and the DipSW, nationally would have been approximately 30, making the group in this study one fifth of the nationally available sample. However for the other two groups of RNLD and DipSW, the sample size would be very small.

Because of this representativeness was an issue. In the qualitative tradition,

representativeness is a form of logic guiding the selection of samples in a study, rather than a quantitative logic of sampling from a population. In grounded theory any groups can be compared, with the proviso that comparison would be consistent with the purpose of the research (Glaser and Strauss, 1967, p.50). At this early stage of the research, I felt it important to have access to a group of individuals with joint (Diploma in Social Work, and RNLD prequalifying experience of interprofessional practice), as well as singly qualified RNLD and DipSW participants, because I was convinced that as students and subsequent practitioners the dually qualified professional had something else unique to contribute. This was based on a feeling that these individuals experienced interprofessional work in a different way , potentially giving them greater explanatory power(Blumer, 1969, p . 148).

Even if this were to be the case, generalisability, was at issue. Rose (1991, p.192) describes generalisability as "The ability to extrapolate with statistical confidence, from that sample to the population from which it was drawn." Nationally, there are only a small number of individuals holding the dual qualification. Therefore, even this relatively small number would be a significant sample. However, in the case of the other two groups the size of the sample would be small, and in some research methodologies, making comparisons across groups difficult. I knew that what was vital at this stage of the research, was the need to present a method of data collection and analysis that could capture the essential elements of meaning to those involved (Fielding and Fielding, 1987, p.35). As Gadamer (1975, p. 6) referring to analytic generalisation writes "The individual case does not serve only to corroborate a regularity from which predictions can in turn be made. Its ideal is rather to understand the phenomenon itself in its unique and historical concreteness...the aim is not to confirm and expand these general experiences in order to attain knowledge of a law. eg how men, peoples and states evolve, but to understand how this man, this people or this state is what it has become."

5.8 Data Analysis

It was at the point of data analysis that things were to became even less comfortable for me. I was still seeking an objective method of analysis influenced by my experience of methodology this far and a notion of what research should be like. Ultimately I wanted broad themes for development of interview schedules. At the same time the sample was small whilst the more developed individual responses on the questionnaire raised a set of questions around

my perception of the 'difference' in the Dually Qualified (DQ) and RNLD and DipSW group. I was still seeking answers not only to the overall research question but to the perceptions of the dually qualified practitioner. As a new researcher I was also seeking structure. Of particular significance at the early stage of the research was the potential of grounded theory methodology, where interpretations in the form of collecting, coding, analysing and presenting data and generating theory (Glaser and Strauss, 1967, p.224) have to include the participants' voices. Equally the researcher must accept and take responsibility for their own action and interpretation of their roles (Strauss and Corbin, 1994, p.274).

Part of this process involves the researcher seeking multiple voices, in this case from practitioners, whilst the process of coding data from theoretical sampling to concept development prevents the researcher from taking more notice of one voice over any other. Because of this, the researcher's own voice is provisional, questioned and questioning (Strauss and Corbin, 1994, p.280).

In order to achieve this, the questionnaire responses (Appendix, A2) were coded using a coding structure guided by Bogdan and Biklen and their exploration of coding categories (Appendix Table A1) (1992, p.166).

The Bogdan and Biklen scheme is described as midway between an inductive approach and a totally determined starting point by Miles and Huberman (1994, p.61). Their structure provided a systematic approach to the analysis of responses from participants. Miles and Huberman (1994, p.62) draw attention to the importance of structure in the ordering and conceptualising of data. A clear or well structured list of codes, linked to the research question, and to conceptual variables enables the researcher to be clear about categories, and how segments of data fit into codes. Poorly structured schemes mean that the researcher has difficulty remembering the categories and codes, and can lead to opportunistic analysis (Miles and Huberman, 1994, p.63). The guidance from Bogdan and Biklen enabled me to develop distinct categories of meaning, with examples of likely content areas. A strength of the Bogdan and Bilklen approach was that the coding structure was not content specific, enabling a development of a provisional conceptual structure.

I included categories for **value driven** statements or meaning. Bogdan and Biklen (1992, p.167) suggest that these perception type statements could form part of the definition type codes. However, these were of particular interest, so were weighted separately, or in addition to one of the other codes. My coding matrix for the questionnaire is illustrated below:

SET	Setting or general information about context
DEF	Definition of the situation. Includes a reference to the situation or a brief response with limited development of the question
DEFA	Includes a positive view of the situation
DEFN	Includes a negative view of the situation
PERK	Ways of thinking about practice that include broad knowledge
FEL A	Ways of thinking about people or practice which includes emotional, values, feelings, views, events, which is affirming.
FELN	Ways of thinking about people or practice that includes emotions, values, feelings, views, events which is negative.

Figure 2. *Coding categories for questionnaire analysis.*

As there had been previous contact with the dually qualified group, the coding process was repeated by a colleague from a different area of practice. The themes that emerged, presented a similar pattern to that of the original analysis. Guba (1989, p.56) writes that sets of categories should be reproducible by another competent judge. The second observer ought to be able to verify that categories made sense and also that the data has been appropriately arranged in the coding system. Further evidence of the integrated nature of the structure was found in that the analysis yielded few diverse or unrelated themes. A major concern was not to let my previously held beliefs distort or obscure any new information found.

The decision making process throughout the use of the questionnaire was a painful one. Dey (1999, p.4) citing Glaser and Strauss (1967, p. 45) points out a major element of the methodology is to avoid preconceptions. In order to achieve this the researcher is encouraged to avoid reviewing the significant theory in an area until after immersion in the data. My immediate response to this was a negative one. I had already been practising in the area of exploration for all of my career, and had used the literature of interprofessional practice to develop my questionnaire. Therefore despite the attraction of the grounded theory methodology I couldn't use it. Later, having reflected on this , I decided that several other factors were at work here, which did enable me to access the methodology. One significant factor was that, in relation to theoretical sensitivity, refusing to privilege any one theoretical perspective (Dey, 1999, p.4) was equally as important as ignoring the literature. At this point, I had not taken forward any particular theoretical view, nor had I completed my analysis of the questionnaire.

Additionally, there were very few theories to draw upon in the field of learning disability practice (Parahoo et al , 2000, p. 608) .

Using a questionnaire to gather data, along with a qualitative tool of analysis, combines methodological traditions, as a result of a research question, which aims to interpret rather than measure. This combination of methodologies reflected my position as a researcher and my struggle with sense of self and the researcher role. The initial approach was based on my view of research as an awesome undertaking which must wherever possible remain under control. However this tended to clash with my sense of self, my way of being in the world (Charmaz, 1997, p.49) and ways of relating to others - hence my approach to analysis of data. I have since learnt that there is space for a range of perceptions and traditions, despite as Fielding and Fielding (1987, p.20) note, "Social scientists following conventional tenets can convince others of the relevance of one level of analysis to the exclusion of the other". Now I feel more comfortable with a position based on a view that (Fielding and Fielding,1987, p.20) there cannot be micro-sociology that studies social interaction as a local self contained production, any more than those who are macro theorists can claim that macro-social structures can ignore micro-processes. Citing Cicourel (1981, p.54) they write "Micro and macro structures interact with each other at all times despite the convenience and sometimes the dubious luxury of only examining one level of analysis." Therefore, researchers need to accept that in undertaking one research paradigm or methodology, often there is indirect reference to the existence of another (Fielding and Fielding, 1987, p.20) .

5.9 Research Findings

5.9.1 Knowledge based Responses

The initial analysis suggested that all respondents had a broadly similar formal knowledge base. However the responses to knowledge type questions were of interest. An example was whether an exam type or set response was given, rather than a more personal view bedded in experience. All of the RNLD group had similar views with regard to the practice setting, and the organisational structures which supported them. They offered practice- based, knowledge-focussed responses and frequently used definition type responses. Negativity was present, but mainly in relation to the lack of opportunity to take the lead in interprofessional work, and in relation to the questioning of other professional roles in the interprofessional context. By contrast the DipSW individuals offered responses related to theory, rather than examples from

practice. This group were positive in their responses, in relation to interprofessional work, but did not in every case, apply their answers to the practice setting. Lastly the group holding dual qualification provided responses which were related to the nature of interprofessional work for example, reflections on practice set within descriptions which were related to values or beliefs held by the practitioner. These value- based responses were more common in the dually qualified group. This group were very expressive in their use of language and this was interpreted in the analysis within both the feeling/ values code and the code linked to the specific setting or other category. The dually qualified group set their responses in the first person more frequently than the other groups. This ownership was present in the other two groups but not with the same predominance. This first person approach was prevalent in both the individual and practice sections of the questionnaire. Across the sample, in terms of passing an examination, related to formal knowledge held, all respondents would have gained similar marks.

5.9.2 Language and Professional Practice

The major differences documented in the analysis, relate to the language used and the context or experience base of participants. Coffey and Atkinson (1996, p. 100) write that "informants use language to convey particular experiences and meanings". Such language can be used to account for social actions, or as Mills (1940, cited in Coffey and Atkinson, 1996, p.101) observes, as "vocabularies of motive". Subsequently, some forms of language or vocabulary may be used to make coherent and or plausible accounts of social events or social action. Whilst Coffey and Atkinson are referring to textual data centred upon talk, there are useful points for exploration in the written questionnaire scripts. Initially, explanations were sought for the shift in emphasis from the general definition type responses, to the more emotional or value based responses within the dually qualified group. All participants in the study may in their descriptions of interprofessional practice, seek to account for, excuse, or justify behaviour. In their responses, they may be aware of the external scrutiny that their script may receive. Accounting behaviour (Coffey and Atkinson, 1996, p.101) or devices are used to produce a plausible construction of the social world. Such accounts are used on an everyday basis to explain unanticipated behaviour or action. The impact of the status of participants, and their physical location may also be influential. Consequently, participants may have attempted to be knowledgeable in their responses, particularly when the research questionnaire has come from

a university they had attended. Additionally, some of the participants would recognise the researchers name, and this may also have influenced the form of response. Further the type of response or account given, may be described as either an excuse type response or a justification (Potter and Wetherell, 1987 cited in Coffey and Atkinson, 1996, p.101). Excuse type accounts, are defined as the use of socially approved vocabularies to relieve questionable action. Examples relevant in this study, would be lack of information or scapegoating used to defend or endorse approaches to, or views on interprofessional practice. The issue of lack of resources as a barrier to interprofessional practice, whilst clearly an evidence based reality, may also be a cause of powerlessness amongst professionals. In some responses, across all of the groups in the study, managers are used as scapegoats.

5.9.3 Justifying Response

Justifications are used to neutralise or attach positive value to action, (Coffey and Atkinson,1996, p. 101). Whilst in this study, observation or verbalisation are absent. The written responses provide a structure in which there are "socially approved vocabularies that may situate an act in a justificatory context." In the context of attaching meaning to script, successful accounts should "be coherent and plausible and draw upon shared understanding and knowledge"(p. 101). In this study, language used by the DipSW and RNLD groups remains largely an unemotive, professional vocabulary. A familiar range of external responses are predominant, and in this case would be seen as valid and persuasive. In contrast, the dually qualified group present fewer excuse or justification type accounts.

5.9.4 Professional Culture

Coffey and Atkinson (1996, p.101) suggest that when analysing accounts or responses, they can be standardised in some way, normally within subcultures or cultures. Through this process, different types of accounts by different participants can demonstrate the "situated and cultural nature of accounts." Equally, accounts use a language familiar to the specific culture. Such accounts usually conform to the norms of a situation. In this study, the norms of the situation may be interpreted as the use of the language of health and social care, and information giving in relation to the external world of interprofessional practice. Persuasive and valid accounts present in the RNLD and DipSW groups resemble elements of the culture of nursing and social work in a range of settings. Loxley (1997, p. 55) describes the occupational culture of

a profession as being closely bound up with its identity, as seen through its adherents, or critics, or society at large. Continuing, she notes that when the professional group identity can draw into itself attributes such as trustworthiness, expertise and wisdom, then it will acquire esteem (1997, p.55). It could be argued that individual professionals in this study are conforming to a professional norm in the use of a specific frame of reference through which its members see the world (Loxley, 1997, p.55), and in the use of defences which enable them to cope in the face of challenge or threat. Furthermore, through a process of education, individuals are socialised into roles with the expectation that on qualification "they are deemed capable and are expected not only to have good social understanding and judgement but good clinical knowledge and judgement" (Dombeck, 1997, p. 361). This leads to a process of role assimilation within which "healthcare professionals learn not only what they should know but also who they should be and how they ought to act" (Dombeck, 1997). Consequently, accounts reconcile idealised, views of practice and its realities. Through this process they have a moral function,(Coffey and Atkinson, 1996, p .104) in establishing the participants' rationality and professionalism.

5.9.5 Professional Accounting

The use of a form of professional accounting by the RNLD and DipSW groups, may denote a cultural conformity. However, the position of the dually qualified group is less clear. Whilst the language used remains predominantly that of health and social care, there are differences in relation to the lack of excuse or justification accounts, and the more distinct use of the self. The language used is more expressive, as illustrated in the amount of value based codes held by this group, and it contains more "slang". Coffey and Atkinson (1996, p.104) note that the use of a more informal linguistic style is often used in small groups in which parties are well known to one another, often as a result of relationships between givers and receivers of accounts. One explanation for this response is that of familiarity, a shared history with the researcher, resulting in a less formal style.

A more expressive form of response could also be viewed as a shift in identity of some of the dually qualified group. Having experienced dual professional socialisation and culture throughout their educational preparation, a different set of beliefs and values, together with an alternative professional identity could be in place. Loxley (1997, p. 55) observes the

development of professional identity through the course of training. As part of professional socialisation, mechanisms to establish group norms are set in place, whilst the establishment of myths which tell the story of the group are perpetuated. A combination of group norms, setting of priorities and defence mechanisms maintain this corporate ethos (Loxley,1997, p. 55). In establishing this identity, acceptable behaviour, language, and styles of management are reinforced. These may be internalised and impact on the professional's perception of self and the profession's view of others. When in practice, perceptions inform the questions and decisions about what is relevant information to a professional and what the main tasks are of a group (Loxley, 1997, p.56).In the case of the dually qualified person, where there has been access to the socialisation processes, of both nursing and social work, choices may have to be made, in relation to a preferred professional frame of reference. Agencies still remain separate across the boundaries of health and social care, and a choice may have been made on qualifying, in terms of joining a particular nursing or social care agency. Exclusion from a professional group may lead to lack of confidence and a lack of clarity in terms of professional role (Loxley, 1997, p.56), in a sense almost forcing a choice of profession.

5.9.6 Professional Equilibrium

Alternatively, some dually qualified individuals may have had to develop their own equilibrium, and practice across professional role boundaries thus working through the feelings of anxiety, isolation and distress, that not belonging can create. Loxley (1997, p. 57) describes the psychological decision making process in professional practice. She suggests that professional ethos and training enable professionals to cope in situations of distress. Consequently, professionals can respond without being overwhelmed. Psychological defences against distress can protect the professional from anxiety, and so can have a positive effect (Loxley, 1997, p.57). However, in some forms of practice, the situation can be so overwhelming that professionals deal with lack of power or response by projecting outwards, for example at another professional group. Loxley identifies scapegoating, denial and avoidance as common defence mechanisms used. In one sense they are adaptive in that they enable professionals to make a response or excuse, but they can also be maladaptive as they can cause a prevention of action (Loxley, 1997, p. 57). Further Loxley indicates that defence mechanisms may have a place in group or individual identity, but could be seen as destructive

if they interfere with response to need. In practising within two professional cultures, some dually qualified participants in the study may have worked through the defence mechanisms presented, and their role in professional and interprofessional practise, and begun to work toward acceptance of a different identity. This difference may have offered creative opportunities for practice, and for both personalising and interpreting interprofessional practice. This could explain the less common excuse or justification type response from the dually qualified group, and the more informal style. It may also begin to explain the greater use of self in relation to interprofessional practice as identified in the dually qualified group's responses in the questionnaire.

5.10 Interpreting Data

Making such interpretations of the data, could be seen as applying the device of "Contrastive Rhetoric" (Hargreaves, 1981). Coffey and Atkinson describe this form of analysis as "accounts in which the speaker and his or her practices or values are legitimated or justified by means of comparisons with what goes on elsewhere, what has been done in the past, or what others do. The contrasts are constructed so as to provide the hearer with the opportunity to recognise which state of affairs is to be preferred" (1996, p.104). With the researcher's previous knowledge of the dually qualified group, and the previously stated opportunistic position taken, analysing the data to achieve such findings could lay claim to such criticisms. Equally the research participants have not confirmed this belief. The researcher could be accused of attaching meaning to the participants' action in the completion of the questionnaire, and in the analysis of the data.

5.11 The researcher's position

On the other hand, the researcher holds a knowledge base and experience of interprofessional practice, and this knowledge does enable the "genealogies of ideas, the key perspectives and the fundamental presuppositions that inform research practice" (Coffey and Atkinson,1996, p.154). The approach taken was a starting point to provide a basis for further exploration or interpretation of research findings. Stage one has validated the literature and research on interprofessional work from the professional's viewpoint. The data analysis so far has demonstrated the researcher's thinking and attempts at understanding the views of the RNLD

and the DipSW, as well as that of the dually qualified individuals.

Intriguingly, the use of power , both professional and organisational remains an issue as it is referred to in various forms throughout the analysis of the questionnaires. For example, powerlessness in terms of scapegoating and excuse type language is present in all of the groups, and with defensiveness in relation to their professional role and organisational culture. Equally the issue of territory or boundaries and the inclusion and exclusion of some professionals from the leadership role in practice is raised. A questioning of some professional roles is also present. There is also reference to the self, in relation to values, and for potential strategies for empowerment, across all of the three groups.

5.12 Next steps and theme development

At this point, a more detailed exploration of preliminary research findings was necessary. To do this there was a need to explore in dialogue, with individuals some of the issues raised in the analysis of the questionnaire. What was needed, was a debate or a "conversation with a purpose"(Burgess, 1984, p. 102) and for this reason, topic focussed qualitative interviews were seen as the most effective method. In taking forward some of the emerging themes from the questionnaire data analysis, a framework of content, based on six themes, was constructed :

Interprofessional practice (Theme 1) Role of the RNLD (Theme 2) Health care roles (Theme 3)
Social Care Practice (Theme 4) Influence of DQ (Theme5) Educational Experience (Theme6)

Figure 3. *Emergent themes from the questionnaire*

The framework and broad themes were designed to ensure that whilst similar areas of interprofessional practice remained central to all the interviews, there was space for individuals to explore practice in a learning disabilities context, not in an imposed standardised context which may have excluded reflexivity. Mason (2000, p, 41) writes in reference to qualitative interviews "You may wish to explain something about social process, social change,

social organisation, and social meaning, and you will argue that this requires an understanding of depth and complexity in say, people's accounts and experiences...". Figures A2-A7 in Appendices, illustrate the process of categorisation.

5.13 Selection of Participants for the next stage of the study

The first stage of data analysis has presented a series of emergent themes for interview structure, with the final aim of the questionnaire being to select individuals for the next stage of the study. In one sense, this aim is inferential, in that value judgements are being made about a likely participant and an accusation of analytical bias could be made, which Miles and Huberman suggest may weaken findings. They assert that researchers may be guilty of the holistic fallacy (Miles and Huberman, 1994, p. 263), in which events or activity or in this case responses, may be made more congruent than they really are. This may impact on the selection of individuals who may then take forward such responses. Additionally, they describe the elite bias, where researchers overweight the responses of more articulate participants, and thus under-represent the less articulate .

More critically, Stake (1994, p .243) suggests that whilst Miles and Huberman draw attention to the need to gain the best possible explanation of a phenomenon (Von Wright, 1971), there may be other reasons for the researcher's selection of participants or cases. Through exploration, other areas of interest in a phenomenon may be sought. Yet a choice of respondent may be made, because that person may offer the best opportunity to learn. Stake (1994, p. 243) observes that the potential for learning, "may be a different and somewhat superior criterion to representativeness." In the area of interprofessional practice, the particular experience of another, in terms of the context of practice, may well offer a great deal of learning opportunities for the researcher. To pursue this learning experience, in part through choice of participants, should help with the process of concept building in the field, which may be under explored in the literature (Miles and Huberman, 1994,p, 263). Equally with the grounded theory methodology I was aware that this group of people might be only provisional and that in order to totally saturate the categories or concepts generated, more interviews might be necessary.

5.14 Questions raised for the researcher

The findings of the initial analysis have indicated that whilst there are similarities in knowledge

of interprofessional practice, among professionals, there may well be different strategies for interpreting and responding interprofessionally. The level of individual, interprofessional confidence or self awareness, may have an impact on this process. Carrier and Kendall in their description of interprofessionalism, suggest that it requires a willingness to surrender work roles, to share knowledge and to integrate procedures on behalf of clients. In order for this to be achieved, they argue that a new form of professional confidence is required, so that "those involved will feel to be of equal status with all engaged in the enterprise". (Carrier and Kendall, 1995, p. 30). Certainly in this research, there is provisional evidence of practitioners for which this is the case and which seems worthy of further exploration. What seems least useful at this point and in this study, is to seek comparisons across the professional groups, despite the original belief of the researcher that there is something significantly different about the DQ group.

Reaching this conclusion has not been an easy part of the research journey for myself as a researcher/ practitioner. Along the way I have been caught up in a idealistic vision of how research should be, and having arrived at this outcome in relation to the DQ group, meant I had somehow failed. My thinking around previously held theoretical influences led me to confront this strongly held assumption. Whilst seeking views on interprofessional practice was the broad area of exploration, I came to the research owning a set of beliefs in relation to one group of participants in the study. Critical thinking around the early research sample, data analysis, coding procedures and findings in the light of grounded theory principles made me look beyond these thoughts and set them to one side. Taking a provisional position in relation to the data acted as the pivot for this. I was no longer desperately seeking immediate confirmation of my beliefs, but confident enough to wait and see what might emerge from the data. Therefore future data collection processes could take place as a result of new thinking and ideas (Glaser and Strauss 1967, p. 45).

I can see that I did achieve the aims of the questionnaire in validating available literature, developing broad themes for interview schedules and gaining respondents for the interview part of the research. Further in my struggles I have also been able to place my beliefs about a particular area of practice to one side, and in doing so not become "doctrinaire" about the evidence available in the research. For as Dey (1999, p.4) suggests, in grounded theory existing ideas of theory and fact do not have to be ignored altogether. Emerging ideas have been explored on their own terms, and any pre-determined beliefs held by myself have been

exposed. There was a real danger that had I not used a semi-structured questionnaire as the first stage of the research, I would have taken my DQ fallacy into individual interviews, subsequently contaminating potential categories with concepts more suited to a different study altogether (Glaser and Strauss, 1967, p. 46). For having explored the evidence so far, I was now in a more confident position to support my actions as a researcher and to listen to interpretations of interprofessional practice from the participants in the research.

5.15 Strategies in Practice

At this point the interpretation of interprofessional practice by some respondents across all the groups, suggests an ongoing engagement with issues of autonomy and power. I suggest that a range of strategies for interprofessional practice. may be operational, which individuals may have developed from a variety of experiences. These strategies may be both complementary and conflicting, working with and against contemporary policy recommendations, and organisational structures. The researcher's aim is to explore more deeply this knowledge base of professionals, pursuing these individual interpretations set within the structures of health and social care, and analysed through a range of literature sources.

Chapter Six

"Its just stuff on a grand scale"

In chapter five, early decision making and the first steps in the choice of a general grounded theory methodology were described. This process involved an account of the researcher's journey in the application and analysis of a semi-structured questionnaire, leading to the development of themes for a series of topic focussed interviews forming the next stage of the research. In this chapter an exploration of decisions made by the researcher in preparation for the interviews, and the nature of relationships between the researcher and the research participants are explored. The interview process itself is discussed within an account of the strategies adopted to achieve a dialogue with participants and focus on the research themes.

From these interviews a first level analysis of data is presented The resulting picture offers a description of the individuals' experience of interprofessional practice, introducing key roles for the practitioner and impacting on the teamwork strategy and subsequent empowerment of participants. The chapter title "Its just stuff on a grand scale" is a direct quote from one of the participants in a description of practice intervention. For myself it describes the very nature of interprofessional practice in the learning disability field, 'stuff' capturing the process of interaction between professionals and people with learning disability and professionals and other professionals. Whilst the 'grand scale' represents the context of intervention and its influence.

6.1 Continuing the research journey

6.1.1 The topic focussed interviews

One of the outcomes of the first stage of the research was the need to explore further practitioner thinking about interprofessional practice in the ongoing support of people with learning disability. A route to achieving this was that of topic focussed interviews, taking forward the emergent themes from the questionnaire analysis (See figure 3). At this point I felt more confident in staying with the individual experience and working towards a provisional meaning for interprofessional actions and processes described. As a researcher I intended to continue to acknowledge my position in the process, "whilst not squeezing out the object of the study" (Bruner, 1993, p. 6).

6.1.2 The topic focussed interviews: Selection of participants

In this part of the study, from the initial eighteen questionnaire respondents, twelve people were selected to form the sample for stage two. Selection of participants was based upon the following criteria

- Participant holding a professional qualification in nursing, or nursing and social work (This includes the RNMH, the RNLD and the DipSW professional qualification.)
- Professional registration or qualification for 2 years. Educated at pre-qualifying/ pre-registration level in the South of England
- Working in practice at the time of the research interview. Areas of responsibility included disability, and learning disability, with one person working across learning disability and mental health services
- Participation in the first stage of the research, the completion of the interprofessional questionnaire
- Individuals had offered an applied practice account or response to interprofessional work in the questionnaire, moving beyond examination type responses. This led to the exclusion of most of the DipSW participants (See chapter 5 section 5.9.1). In making the decision to exclude people, I was conscious of the point raised by Morse (1991, p. 127) who describes a good informant as one who has the "knowledge and experience the researcher requires, has the ability to reflect, is articulate and has the time to be interviewed." Equally Glaser and Strauss (1967, cited in Bryman, 1996, p.117) advocate that the qualitative researcher should consider whether the sample conforms to the researcher's emerging theoretical framework. Those participants whose responses where embedded in practice regardless of the positive or negative message accompanying them, were seen as significant partners in the continuing exploration of interprofessional practice and the development of theory. Patton (1990, cited in Morse, 1994,p.229) suggests that the logic behind selection of informants, should be to ensure that the sample is information rich. Finally as Morse summarises: "Participants are representative of the same experience or knowledge; they are not selected because of their demographic reflection of the general population" (Morse, 1994, p.229)

From the twelve people approached, ten individuals responded positively to take part in stage two. At this point, five individuals held the RNLD qualification, and four held the RNLD and the DipSW qualification. All were employed as RNLDs in their current post in practice. One

person held the DipSW, and was employed in social services, however the participant's transcript was not used in the data analysis (see below, section 6.2.1).Brief vignettes of this sample are provided in appendix 3. Participants were self selecting in that they responded to an individual letter of introduction from the researcher.

At this point I made the decision not to undertake any further DipSW interviews. The research journey had led me to focus on those professionals involved in the ongoing support of people with long term health and social care needs and felt that team based social work professionals would have less experience of working in this way. Whilst recognising that this might have limited the research at this point, and it is true that this groups views were not explored, the broad topic of the research was interprofessional work, with emphasis on long term support. Whilst noting that this does not give the broadest picture out of the original sample and could be viewed as a limitation of the final research outcomes, I have since felt that I could explore this groups' response to the framework itself, in future studies.

During this time I was exploring the researcher role and my levels of comfort within it. Three key roles were of particular interest, notably the impact of my role as a researcher with potentially marginalised professionals, the nature of the researcher role in a marginalised field of practice and the possible restrictions that a 'researcher as expert' role might create.

I was conscious that in self selecting, individuals might wish to seek an audience to air a particular view. For example Blau (1964, p. 30), describes his experience of fieldwork in ethnography, where his early contacts were people keen to voice criticisms of a particular agency. Had he not realised his research may have given a distorted picture. In the selection of participants for stage one of the research, a criterion for inclusion, was employment in the health and social care field. Participants were employed in a range of posts and agencies, so it is unlikely that any one particular organisational view would be conveyed at the exclusion of others, and at this point all data generated would be viewed as provisional.

Additionally, I was also aware of my previous link with the DQ group and my exploration of both their familiarity in the use of language in the questionnaire responses, which could have been about getting a particular message across, and my earlier belief that they were somehow different as practitioners. I decided that the general principles of grounded theory, with the ongoing evaluation of my own role in relation to the participants and data generated, would make all relationships transparent. Further themes for the interviews had been derived from the questionnaire analysis and a strategy for the interviewing process had

been planned which was to enable participants to determine areas of exploration in relation to the topic area rather than my self as the researcher.

6.1.3 Planning topic focussed interviews: The researcher role

Blau (1964, p. 30) in his discussion of marginalisation, makes a further point in relation to the role of the researcher. He argues that the marginality of the researcher may render them attractive to those who are marginal in the settings, or in this case professions in which the research is carried out. Here the connection between researcher and research participants is that of professional practice with a marginalised client group, people with learning disability. This could have influenced the desire to participate in the research for respondents. However, the central theme of the research is interprofessional working, and this was stated in letters seeking participation. Nevertheless, respondents may have decided to nominate themselves to take part because they felt a desire to share a particular viewpoint. However no particular viewpoint had been expressed by myself and there was no research hypothesis only a broad research area. My belief was that a shared area of interest, that is a connection with practice could only be fruitful on the research journey.

6.1.4 Planning topic focussed interviews: The relationship with participants

Whilst there was previous contact with some of the participants in the study, the social world of the research interview represented a new form of interaction for both participants and myself. This could have influenced our level of comfort in any exploration of interprofessional practice. During the planning of the research interviews, and the pre-interview briefing, I was concerned that my action may have been interpreted as being that of the 'expert' (Hammersley and Atkinson,1995, p.81), despite my feelings of owning interprofessional knowledge at an exploratory stage. Together with participants' unfamiliarity with the research interview situation, this could have placed me in a position of power from their perspective. For whilst research that is collaborative seems to demand a common focus (Friesen, 1995), the boundaries of commonality may have been narrower than initially anticipated. Because of this I took a series of steps to overcome any potential power in-balance as part of the interview planning.

6.1.5 Planning topic focussed interviews: The research interview

Mason (2000, p.43) writes that "qualitative interviewers have to work particularly hard on the

structure and flow of the interview"(Mason, 2000, p. 43). In preparation for the interviews, a concern for the individual participant's comfort, and for some structure in the interview itself influenced planning. Tape recording of the interviews was planned and technical equipment organised, as this seemed the best way to enable revisiting of the data. As Mason (2000, p. 53) notes, "You need to be aware that however objective you try to be in your own records, you are continually making judgements about what to write and record... your records need to provide the fullest justification for your own decisions" (Mason, 2000 p. 53). I decided that full transcripts should be taken and tapes held for revisiting, during the data analysis. Additionally transcripts could be forwarded to participants for validation. Consent from participants to use the tape recorder was gained initially during the pre-interview briefing, and at the interview itself.

It was not my intention to create an environment in which people would feel threatened, or that the interview content would seem abstract or non practice focussed. I did not want to be guilty of "simply translating the research question into the question for interviewees" (Holloway and Jefferson, 2000 p. 35) Therefore whilst the earlier questionnaire gave a shared starting point for both the researcher and the participants it was to be used only as a point of reference, with the practice area of learning disability giving a shared frame of reference. A pre interview briefing (by telephone) took place for all participants and this ensured that concerns in relation to time, personal safety, and confidentiality were addressed.

6.1.6 The structure of the interview

As the researcher, I did not wish to dominate the research interview, whose main purpose was an exploration of the practitioners' knowledge and perspectives. Therefore, whilst the themes from the questionnaire gave a framework for all the interviews and acted as a prompt, I did not organise the theme areas in any order of priority. My intention was to have a starting question, to relax the participant and set the scene, and then focus on the person. The themes could then be used at appropriate points. I used a note book to write the key points for the introductory question, which would then be individualised, and to list the key themes. Other notes could also be added if needed, but I felt that copious note taking would be intrusive, and impact on listening. Aware that as Mason warns " Do not assume that a transcript produces an objective record"(Mason, 2000 p. 53), I decided to write post interview notes for each participant. These covered initial feelings and thoughts about the event. I did not feel that non verbal elements of

the interview counted as data and did not make plans to measure them in the interviews. However I did plan to use non verbal cues, to pursue particular avenues, ideas and statements and to gain richer data. My first question and how it was phrased needed particular thought, as I was aware of its significance in opening up the dialogue between myself and the research participant. I decided not to go for an insignificant opening question, but to use "Tell me about your experiences of working with other disciplines" and set it in the individuals practice setting.

6.1.7 The interviews

In the interviews themselves, the prior preparation and the development of the theme framework, gave me confidence and enabled me to relax and listen to the participants' accounts. At the start of each interview a discussion about consent took place and an agreement made with each individual about the interview itself, tapes and transcripts, and subsequent publication of the data and what that might mean. For whilst the topic for the interview was interprofessional practice and not in itself sensitive, I wanted to make sure that participants could renegotiate consent or the focus of the interview if they were uncomfortable (Mason, 2000, p. 58).

6.1.8 The themes and the interview process

Preparation of the interview and the first question provided a clear starting point, and led into a description of current professional and interprofessional roles for each individual. Inevitably in some of the interviews, this came out almost in a list format ie other professionals they were working with. However where this was the case, I used a further cue "what has it been like ?". From this point all interviews were free flowing, although there were times of silence when individuals were thinking about responses. The interviews may have been free flowing because of the similarities between myself and the participants, in terms of practice background Holloway and Jefferson (2000, p.66) describe the significance of the researcher's own subjectivity in the interview setting, and note how it can both guard against bad interpretations and assist with good ones. This subjectivity although not necessarily shared with participants may have helped bridge potential differences (Holloway and Jefferson, 2000, p.66) and contributed to the relaxed and unforced atmosphere in each interview. The themes from the questionnaire (see Figure 3. p. 83) are listed below and provided an overall structure for the

interview content.

- Interprofessional practice(Theme 1)
- Role of the RNLD (Theme 2)
- Health care roles (Theme 3)
- Social Care Practice (Theme 4)
- Influence of DQ (Theme 5)
- Educational Experience (Theme 6)

It was not necessary to deliberately introduce themes 1-4 in the interviews. They were central in the dialogue, and a rich exploration took place. There was little material that could at this stage have been judged irrelevant. However the researcher had to introduce theme 5 Influence of DQ and Theme 6 Educational experience at an appropriate time in each interview. On reflection this may account for some of the findings in the initial data analysis (see below section 6.2.1).

6.2 Following the Interviews

6.2.1 The data

On completion of the interviews, all tapes were transcribed in full. The code Rn and a number from 1-10 , was given to each transcript for identification, for example Rn 1. The preliminary stage in the analysis was to read through each text. The notes made by myself at each interview were referred to and reflected upon. This first look at the scripts was significant, as through the process, judgements on the potential quality of the data were made. Mason (2000, p. 136) invites the qualitative researcher to ask ; "What sort of social explanations can be built from my data, and what kind of social explanations are out of its scope ?". In order to get to this point, there is a need to bring together current analytical thoughts, the original research design, the research questions and the intellectual puzzle (Mason, 2000, p. 136). The research process so far, is presented sequentially, below (see figure 4).

Step One	Questionnaire themes from the broad health and social care context on interprofessional practice

Step Two	Coding of questionnaire using the Bogdan and Biklen (1992) coding structure
Step three	Analysis of data, a concern with language used in text and its significance. Researcher beliefs challenged.
Step Four	Data categorised and analysis gives broad textual description of interprofessional practice
Step five	From this analysis, themes for interviews emerged. These gave broad framework for dialogue
Step six	Interviews undertaken and themes explored
Step seven	Transcripts made, and preliminary analysis Relevance of one transcript (Rn10) questioned. Decision to exclude Rn 10 made. Data categorised under the six broad themes of the interview framework

Figure 4. *Steps towards data analysis*

Therefore at the third reading of the data under the six themes, it became clear that only a partial exploration of theme five, the influence of DQ would be possible. There was insufficient data available for this theme (see figure 5 below). In contrast there seemed to be a richness in the quality of data in the other five themes. This lack of evidence in the DQ theme was of interest, in that it was one of the themes that had to be introduced by myself. Equally the text from one interview has not been included in the data analysis process. On review of the transcript from Rn 10, I felt that the focus and nature of content was not valid. The decision not to include the data was based on a series of concerns. Firstly the content of the text was largely of a personal nature, related to the individual's personal life experience. This shift in focus had occurred following the introductory question, and when the participant had been asked what their interprofessional relationships had been like. Whilst there had been no need to prompt the participant to explore the themes that had emerged from the original questionnaire findings, each reference to interprofessional work resulted in a return to a personal experience which, for the participant, had been very significant. As this experience was not directly related to interprofessional practice or the field of learning disabilities, I could not see a means of capturing these views, set within the context of this research, although I also was aware of the need to scrutinise the contrary as well as confirming case in the analysis. Additionally I

would not have been being true to the person, in that their major issue could not be addressed in this research, without significant changes to the context. Equally there would have been a danger of fragmenting the data, and a danger of statements being "Difficult to categorise unequivocally with respect to their meaning" (Kvale, 1996, p. 224).Therefore as in the case of the DQ theme, the decision was made to exclude it from the data analysis. Thus the data from Rn (10) was not included in the analysis of themes.

Step Eight	Second broad review of data under the six themes.
Step nine	Re-emersion in data, original research question and findings of questionnaire
Step ten	DQ category in themes is not taken forward due to limited evidence
Step Eleven	Data now categorised under five themes Now ready for further exploration of categories.

Figure 5. *The next steps in data analysis*

At this point I had finally to set aside the belief that the research was going to say something novel about the dually qualified experience. Instead the research journey was to continue, driven by what the data offered in the next stage of the analysis.

6.2.5 Data themes to take forward for the next stage of the analysis.

Having made the decision to put to one side the DQ theme, the data could then be revisited. This subsequent exploration offered a further level of category development (figure 6 below) within the original five theme areas.

CATEGORIES	THEMES				
	RN LD	**Social care Practice**	**Health**	**Interprof Practice**	**Educational Experience**
	Contemporary Role (R)	Role Shift (Y)	Role of Health Professionals (F)	Boundaries(B)	Client Group As Motivator (MC)
	Claim to Practice (K)	Control of Resources (G)	Validating Practice (VP)	Interprof Knowledge(P)	Develop A Position (W)
	Professional Recognition (D)	Communicatio n (T)	Medical Model Lead (M)	Affirming (A)	Skills and Knowledge Gained (X)
	Professional Devaluation (DE)	Criticism (J)	Questioning Practice (Q)	Client (CL)	Negative Experiences (Z)
	Professional Empowerment (E)	Contemporary Role (H)		Crisis (C)	

Figure 6. *Data analysis : Themes and categories*

6.2.7 Categories and properties

In the process of data analysis here, the term category is used in a particular way. Categories such as contemporary role (R) have been created in order to make a distinction, based on a comparison with other categories. Dey, (1999, p. 54) writes that something has properties or dimensions, but it doesn't have categories. Rather the 'thing' is assigned to a category, which is how we chose to classify it. Thus 'contemporary role' is a category which has been created to include the properties or examples of contemporary role from the data and which belong to that particular category. The properties of the category 'contemporary role' may be distinct from or connected to those of the category 'claim to practice' and it is my interpretation of the data that makes the claim, based on the context which is interprofessional practice. Where examples of difference, connection and interaction between categories occur, as Dey (1999, p. 57) notes the concern is with how one thing affects another. Such interactions may be based on substantive or formal relationships. Dey (1999, p. 58) cites Sayer (1992, p. 88) who describes formal relations as those of similarity and difference and substantive relations as interactive relations based on connections.

Additionally category membership has been made through degrees of resemblance to the best examples or prototype, rather than sharing all of the common features of that category (Dey, 1999 p. 70). For example Professional Recognition (Category D) features properties which illustrate the RNLD definition of role with particular reference to the desirability of the

role in practice, their unique qualities. Equally Category R (Contemporary Role) also refers to uniqueness which could have also made them eligible for Category D. However there is a more developed emphasis on the active properties of the RNLD which relate to their current practice role, giving them a set of attributes to form the Category R (Contemporary Role). Therefore at this stage a rich description of categories and their properties forms the first level of data analysis. There are both substantive and formal relations of categories presented in an overview of the professional role in the long term support of people with learning disability. Predominantly participant accounts depict the likely outcome of a set of interactions in the practice setting and how these are explained and responded to. The tables below outline the process of membership for each category across the five themes.

Category R Contemporary Role :	Emphasis on the active properties of the RNLD
Category K Claim to Practice	Descriptions have developed sense of professional role. This offers more than engagement in their own contemporary role, with reference to moving into other areas of practice as and when required.
Category D Professional Recognition	Includes evidence of difference, set in confident description of an emerging role Properties in relation to level of confidence set this category apart from category K. Also reference to uniqueness which makes it distinct from Category R, which also has a contemporary role element.
Category DE Professional Devaluation	Properties include reference to potential marginalisation, either by professional action or in a more abstract sense.
Category E Professional Empowerment	Stated preparation for positive use of power, either in defence of professional RNLD or combined with advocacy in terms of service users and or other professionals.

Figure 7. *Category Membership : Theme :RNLD*

Category Y Role Shift	Properties include understanding of social work role shift and a reference to the lack of accountability taken by social workers despite this transition.
Category G Control of Resources	Here properties include concern over a lack of shared accountability across health and social care based on not meeting need Differs from category Y as properties relate to both health and social care failings. Differs from Category Q which relates to professional activity only.
Category T Communication	Properties include direct reference to communication as well as reference to a strategy for changing the current level or style of communication. Many of the other categories include communication, for example Category B Boundary. However difference in terms of properties has been made because context for communication is centred on the issue of boundary rather than professional strategy to create change.
Category J Criticism	Reference to likelihood of unacceptable practice by a different professional group. Membership of this category occurs where this is directly expressed, rather than as a need to attend to other professional practice as in Category VP.
Category H Contemporary Role	Properties relate to the Role of Social Workers in relation to Statutory and Legal requirements of current practice

Figure 8. *Category Membership: Theme: Social Care Practice*

Category F Role of health professionals	Properties relate to types of relationships within health service teams. These are separate and distinct from those with social work and are described so. The property is centre on relationships as a basis for inclusion.
Category VP Validating Practice	Active and open professionalising agenda for the RNLD. Not linked to client need. Based on maintenance of the role of the RNLD.
Category M Medical Model Lead	This category had neither a distinct or adequate set of properties to form a separate category.
Category Q Questioning Practice	Properties of this category relate to the need to attend to other professional responses. There is an action component based on professional responsibility rather than in relation to clients. Not centred on bad practice as in Category J.

Figure 9. *Category Membership : Theme : Health*

Category B Boundaries	Properties include direct reference to boundaries. Offered as a reason for confusion in practice intervention.
Category P Interprofessional Knowledge	Properties include strategies for effective communication, based on the professionals' stated interprofessional knowledge and experience
Category A Affirming	Properties include a definition of interprofessional practice set within a positive rationale for its use. Also includes evidence of interprofessional knowledge as category P. Distinctness of category is the positive endorsement of interprofessional model. Properties do not include reference to formal education as in Category X.
Category CL Client	Properties include those which link intervention to needs of person with learning disability. Not always linked to a defence of the RNLD or other professional role. Therefore distinct from Category Q Category E and Category MC.
Category C Crisis	Properties have a direct acknowledgement or reference to the very real and constant place of conflict or crisis made by the practitioner.

Figure 10. *Category Membership : Theme : Interprofessional Practice*

Category MC Client group as Motivator	Client group interest as rationale for intervention. Linked to a driver for intervention.
Category W Develop a position	Connection made between formal educational experience and personal change. Distinct reference to self, which separates properties from Category X
Category X Skills and Knowledge Gained	Properties link formal educational experience to practice intervention. Properties are positive endorsement of this experience and how it helps in practice. This creates a distinction from the properties of Category Z.
Category Z Negative Experiences	Properties include a description of marginalisation in formal educational experience which was viewed as predominantly negative. In contrast to the properties of Category X.

Figure 11. *Category Membership: Theme : Educational Experience*

6.2.12 Some initial thoughts

In the trail through the transcripts, some clear pictures were emerging. Firstly that there is a significant amount of information on interprofessional practice. This has supported my original

broad research question and methodology stages. Professionals interviewed for the study, hold a wealth of knowledge about interprofessional practice and the skills involved, whilst their descriptions of the collaborative process in team work, indicate a concern with a the context of practice and its ongoing evolution. The data offers a rich picture of the contemporary role of learning disability practice. The knowledge presented, alongside the critiques of the context of practice, offer a comprehensive description of practice experience.

Practitioners describe strategies for good practice, and role evaluation and appraisal. An awareness of the nature of marginalisation and an emerging interprofessional confidence, are characteristics of participants' experiences, whilst perspectives on working through conflict, risk taking and trust shape the route to powerful practice. At this stage I was disappointed about the lack of supporting data for my original ideas about the DQ role, however this was mitigated by the real evidence in the data for a further theoretical layer of analysis, which had the potential for a conceptual framework for practice and which could be taken forward, following the descriptive analysis level (Figure 12).

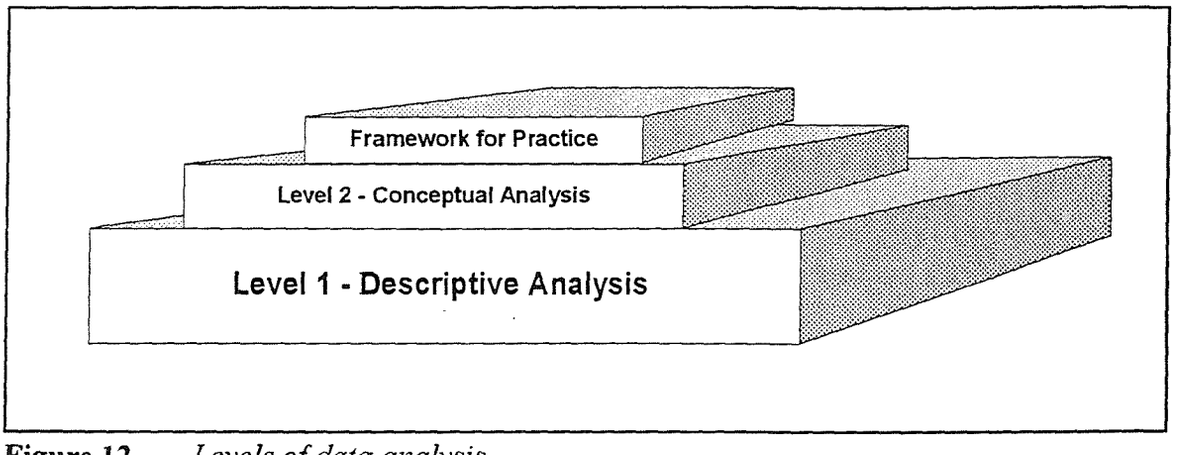

Figure 12. *Levels of data analysis*

6.2.13 The descriptive analysis : Stuff on a grand scale

Mason (2000, p. 137) suggests that a descriptive account involves an explanation of what is going on in a particular social location, or within a set of social processes, which in this study is the practice setting. Mason (2000, p. 137) warns of attempting to offer a completely neutral descriptive account, suggesting that the researcher needs to be clear about data selected to explain particular factors. For the purposes of this research, data selected for the level one analysis offers a way into an explanation (Mason, 2000, p. 139) or interpretation of practitioners' experience.

Level one analysis is not offered in isolation from the level two interpretation. My approach to categorisation has included both categories I have constructed myself and those that have come straight from the research situation (Glaser and Strauss, 1967, p. 107). For example category C Crisis comes straight from the context of the research in daily practice. Whilst Category DE Professional Devaluation reflects my analysis of participants' description of their interactions in a situation. To put it simply participants did not say "I am professionally devalued" rather participants described their feelings in relation to being marginalised or invisible (see section 6.3.8 below). It is my interaction as the researcher with the data which has led to the interpretation and development of this category.

At this stage categories presented sit within Glaser and Strauss'(1967, p. 241) description of emergent concepts, being both analytical and sensitising, with general properties whilst also being meaningful to the people concerned. Thus the categories have meaning both in and beyond the local context and at this stage remain provisional. The next stage of category development will formalise the local category development in the foundation of a conceptual framework for practice, and for changing interprofessional practice. This will form the content of chapter seven.

6.2.14 The significance of description

By presenting and exploring data through a process of description, issues arise in relation to the interpretation or meaning given to the data and the significance of the research findings to a wider audience. In this analysis, the descriptive strategies adopted, draw upon the researcher's interaction with and interpretation of both previously explored and novel areas of knowledge.

This use of literature has enabled a shift in the type of description, beyond the thin description described by Denzin (1994, p. 504), which is independent of intention or circumstances, to a thick description which contextualises the experience (Denzin, 1994, p. 505). Through this generation of description, the researcher has made judgements with regard to the interpretation of research participants' views and knowledge in the practice area of teamwork. Thus here in this descriptive analysis, literature, professional experiences of participants and the knowledge base of the researcher have influenced the questions asked of the data, on the route to theory generation described.

6.2.15 Presentation of data analysis

The purpose of presenting data in textual form is to illustrate points made by participants, and to support interpretations made from it. Bogdan and Biklen (1992, p. 190), suggest that quotations tell the reader, not only what was said, but convince the reader of the plausibility of the interpretation made.

Making decisions about what text to include and exclude has been a part of the process of descriptive analysis. Gaining a balance between enabling participants' views to be expressed, whilst ensuring that text is not seen in isolation, remains a key challenge for the qualitative researcher. As Bogdan and Bicklen write, the aim for the researcher is to say to the reader, "Here is what I found, and here are the details to support that view" (1992, p.189). In the selection of textual data for presentation, it is recognised that a position has been taken in relation to the emerging themes. Some text has to be given priority for presentation, which in itself remains a subjective process. Themes explored have been developed through the data analysis process described whilst where material was lacking, in this case under the DQ theme, the data available for analysis has been excluded.

Equally Bogdan and Biklen (1992, p. 190) note that there are no formal rules for presentation of data. From their own experience, Bogdan and Biklen offer several ways of presenting qualitative data (1992, p. 190). These include the following:

1) A mixture of quotations from participants, with the researcher's own description and analysis all in the same paragraph.

2) Presenting data as a statement and then illustrate the statement with several examples. Each of the examples offering a slightly different aspect of the general point made.

3) With a colon, whereby the colon indicates that material presented will illustrate preceding sentences (1992, p. 191)

4) Incorporating data directly into text, in an informal style like story telling(1992, p. 191).

In this chapter a variety of presentation styles are used. Predominant is Bogdan and Biklen's second example where the data is presented in relation to a statement, and then illustrated with

several examples. On some occasions, individual pieces of text are used to support statements, whilst text is also drawn from a larger piece of presented text, to endorse a statement made by the researcher. Care has been taken to create coherence in support of statements made, without losing the participants' view in relation to the themes explored.

6.2.16. Prioritising data

Figure *6.* outlines the process of developing themes and the subsequent categories. These themes and categories are highlighted in diagrammatic form above. All categories of data are explored, and identified in the appropriate section of practitioner accounts, with the exception of category M :-Medical Model lead. Following the process of analysis only one small section of the transcripts was placed in this category. After several readings of the text, I asked myself a question from Mason (2000, p. 143). "Is this slice, segment or form of data illustrative or constitutive of my explanation ?" On reflection my thoughts were that it was only one illustration of the category, and that my explanation of the place of the medical model was contextualised under categories Q, Questioning practice, Category K, Claim to practice, and Category F, Role of Health Professionals where the role of the RNLD and relationships in teams are explored. Therefore a decision to remove category M from the interpretation was made. Throughout the data analysis, decisions have been made about the selection of quotations for citation in the text. Mason (2000, p. 144) observes that the researcher needs to "Explain what is the relationship of the quotations or slice of data you have chosen to cite, to those which you have not". For this research, a qualitative decision has been made in relation to typicality and articulacy. (Mason, 2000, p. 144) of the cited text. The major purpose of the descriptive data analysis is to offer an "accurate portrayal" (Morse, 1997, p. 172) of the context in which the practice of the participants occurs. Thus those quotations are cited which offer the most comprehensive overview of practice experience. Additionally, cited text makes transparent the links made between data and the available theoretical literature at this stage of the data analysis.

6.3 Practitioner Stories

6.3.1 Teamwork structures

Practitioners' descriptive accounts of interprofessional working establish the contemporary nature and shape of teamwork relationships. These involve the research participants in more

than one form of team, and within these teams, in established and emerging forms of professional relationships. The influence of both the historical, institutional and medical models of care and the emerging primary care models are represented, in the shape and type of teamwork relationships developed. Connections with hospital based services are still part of practice for some individual practitioners:

> *"We are often dealing with existing hospital set ups within the area, so it may be with various consultants, the eye department, opticians within the hospital, psychologists for example, if we have people diagnosed on the autistic spectrum, we would get specialists in to support the team and make recommendations for the future". (Rn7).*

As are traditional links within hospital based services :

> *" There would be twice weekly input from the consultant psychiatrist, and also in between from the locum, they would typically be coming in to check medication"(Rn7).*

The shift in policy in line with the community care act, and the current government's desire to "jettison the emphasis of the previous administration upon markets and competition" (Hudson, et al 1999 p. 237), has created a wider set of developing relationships and networks is in place, here in Category F, Role of Health Professionals :-

> *" Because the first thing that happens, because we are working to a model of care across a range of needs in health, we are as a matter of course now liaising with dietetic services, it may be out of that comes working with other specialists in the care of dysphagia, other people on dental services" (Rn5).*

> *" In terms of connections, the primary health services and community based services, yes I can go down to their bases and have regular contact with them" (Rn3).*

Participants are all experiencing differing levels of team integration. Looser teams may be described as networks, where practitioners work with a particular client group or come from the same geographical area. Each agency has separate policies, and procedures, and clients are likely to see different professionals at separate exit and entry points. Here the rationale for this type of intervention with health care agencies is given :

> *" You could run a service for people, all would have different primary needs Eg a skin condition, asthma, a mental health need, a learning disability or a combination of all so you have to think about individual need and what input from other health care professionals is needed" (Rn 4).*

None of the participants in this study is fully integrated within team work settings and the majority are members of a number of looser knit teams. There may be sense of informality about these relationships:

> *" Colleagues in the team will get asked to do an assessment of bowels let's say and very rarely will they just do so, they will review their (The clients) epilepsy, their medication, they can't help it" (Rn 2).*

With a sense of professional mutuality about intervention:

> *"Some of the health care professionals are really good to work with, GPs and consultants particularly. We have recently taken a referral from a doctor where the person has clear medical needs" (Rn8).*

Together with reciprocal forms of liaison :

> *"Health visitors have looked to us more, so we have been more willing, more helpful and they have looked to us, because they are looking for guidance themselves and they see us as having more knowledge"(Rn1).*

"We pass information from ourselves to the health visitor and back again, and they may make referrals about a particular person" (Rn8).

The interprofessional relationships in health care practice, are based on the coordination of support and treatment for people, with the RNLD using their skills and knowledge to support the complex health care needs of individual people with learning disability :

"With the Occupational Therapist we work towards getting better equipment for people, for example a part for a wheelchair, a piece for a bed. The OT knows which is the best bed for someone's posture same goes for the dietician, they know the nutritional needs for a specific person and we can actually make a compromise between clinical need and philosophical need without much hardship. They give advice and record it in notes and care plans" (Rn 3).

There is a concern for individual primary need at the forefront of decisions about liaison, for example :

"You have to think about individual need and what input from other professionals is needed" (RN 3).

There is a sense that the RNLD is driving treatment or support for people :

"The bottom line is that changes or recommendations are usually made by the nursing staff and these would be put to the medics, maybe an increase in anticonvulsant or a decrease in medication" (Rn 7).

With a clear understanding of other professional roles as they coordinate care :

"A district nurse would be supporting people's chronic health care need, a mental health nurse assesses people's mental health need and try to meet them through a

range of therapies, thus coordination and management of care is crucial"(Rn3).

There is a more specific attention to individual health care needs of people with learning disability as an incentive for collaboration in health care:

> *"Often there are things that have to be resolved and quite often we give the lead to the consultant psychiatrist and whilst theoretically we might be driven by their perceptions, ultimately someone comes to us through thirs route and then they have access to our service" (Rn 7).*

What is interesting in these descriptions is that these relationships are described through a grounding in practice, and remain at least in terms of identifying roles and intervention, unfettered with resource, status or agency issues. In the accounts above, people are clear about this strand of their professional role and function in health care. The impression given is that these practitioners are the professional group striving for change in the meeting of health care needs of people with learning disability. Health is seen as important and the role of other health care professionals valued, with the RNLD having ownership of the coordinator role . Thornton's (1999) research into primary health care needs of people with learning disability and the co-ordination of intervention would also endorse this role.

6.3.2 New boundaries for practice

Health care relationships are only one element of the RNLD team work role, collaboration with social workers and social work teams being another, with a more formal statutory link at its heart. This is described both in terms of the role of social workers :

> *" Social Workers are more involved with broader things to do with the family rather than just the person, issues with the family and family relationships. They are going in from a different angle as well. It is sort of that their spectrum is a lot bigger I think and they can be dealing with lots of different things and focusses" (Rn 1).*

> *" A social worker would be able to say I manage this case load, and I access this*

budget or coordinate this service to meet peoples' needs this is what a social worker does" (Rn3).

and the likely direction or emphasis of intervention in the light of changes in the Community Care Act (Category H, Contemporary Role Social Care):

"The social worker is going to carry out a social care assessment to actually identify what her (the persons) needs are, whether they have changed over the last couple of years and to see why since the last assessment was carried out why haven't her needs been met " (Rn7).

"We are working towards a middle path with social services, joint planning and commissioning, but there is still some work to do" (Rn3).

"You have to be very clear about what their (Social Workers) legal obligations are they have to operate within the Children Act and the legal frameworks of mental health. Once you can be clear about that it is fine. There are times when you have to work across teams and again most of that is with social services"(Rn4).

Subsequently, when teamwork roles are discussed, there is both an acknowledgment of a shift in the practice of the social worker, and some clarity with regard to the role boundaries of those involved in meeting the needs of people with learning disability. There is no evidence of a limited understanding of the role of social workers. Equally there is evidence of role specificity and an acknowledgment of the leadership role of the social worker:

"They are the ones responsible for changing what goes on in a family, for bringing about action. We also do that but they are the ones making the decisions and saying what will happen, but they are not necessarily the ones that will carry it out" (Rn1).

"Coming from a hospital background, if I was involved in a clients case, I'd be pretty much responsible for all the spectrum, you would be the main coordinator,

now working outside the health authority or trust, the majority of responsibility would fall on social work, so whereas in the past I would have put a whole package of care together for clients including social needs, now my work is very much to do with behavioural issues which are bound to include or reflect social needs, and we will do the work to set up the social needs network, but the actual management and budget issues are passed firmly back to social services, which is good you don't get bogged down and they should be better skilled to provide that service" (Rn2).

6.3.3 Accountability for practice

However, there is still some evidence of role ambiguity when the location of, or accountability for practice intervention with people with learning disability is addressed. Thomas (1991, cited in Dobson, 2000, p. 25) suggests that role ambiguity and role expectation can be a source of tension, within small teams that meet infrequently. Equally, innovation from another profession may be viewed as suspicious and neglectful of their true role, leaving a service deficit. In this case a concern with social work role change is explored in relation to accountability, in the (Y) category (Role Shift). For example:

"Although having the main responsibility for the client group, they don't seem to have the accountability and responsibility to make those decisions, they have to go and check and check, and you don't need that, you need someone sat at the table that can actually make those decisions, may not be in a position to make them but will make them and carry the flack later. That is in terms of the larger issues" (Rn6).

"It is just stuff on a grand scale, where you are working on an emergency placement breakdown or in someone's community placement and you have gone in to offer support in the transitory placement. You are supporting the client emotionally, physically and behaviourally and the only job for the social work department to do is actually offer some stability. There seems to be a reluctance within social services to actually make some of those decisions and sort out resources and you would expect social services to take responsibility and get some support from their senior managers but this is sometimes not the reality" (Rn 7).

The quote from Rn 7 and in particular "stuff on a grand scale" captures the spirit of some practice intervention. For despite a clarity of role being present where the statutory social work processes are concerned, at times relationships can seem ambiguous. This comes across as both a sensitivity to the differing roles of nurses and social workers, together with some criticism of the lack of attention to the divergent areas of practice from social service agencies. The boundaries between health and social care resources are unclear and may add to the uncertain foundation of some forms of collaboration (McGrath, 1991, p. 7). Here the boundary theme (B) endorses this from the practitioner perspective:

> *" Where there are professional or interprofessional boundary issues, obstruction can happen where there are members of teams across health and social care, where everyone has their own agendas within that. Also I think it can be quite confusing if there is a lot of hands on involvement, but social workers don't tend to operate in that way. For us in challenging behavior services, we tend to work quite intensively, so I think some of those confusions are dispelled and if there are confusions about role we will be around to deal with it. I think if you have got a good practitioner, a clinician, then you can still create change, but if the social worker is about the care package then it limits it, they could add so much more" (Rn8).*

> *" I have been involved in a case recently where we had to call a review meeting for someone on order to clarify professional boundaries" (Rn 1).*

> *"It is very difficult to expand on, a lack of communication was blatant and I found it very difficult and not the way to get things done a lot of it was attitude from health and social services, all over nothing really. All issues could be resolved all that happened across the two agencies, could have been sorted out through clearer parameters and communication" (Rn4).*

6.3.4 Control of resources

Equally, the control of resources and the conflict of interest this creates for professionals may impinge on interprofessional relationships. For whilst direct payment schemes and devolved

budgets are presented as good practice in the government's learning disability strategy for the 21st century (DOH, 2001, p. 48), they remain rare in current practice. Thus the care management role, which may represent the client and set budgetary limits for service delivery, remains a conflicting one. Block purchasing of services results in a situation where purchased or contracted services are not aimed directly at a specific individual and their needs, but must meet a more generic need (Stainton, 1998, p. 141). The influence of such organizational tensions, is referred to by practitioners (Category : Control of Resources, G):

"It is seen as important that residential services put one over on day services or social services put one over on health services and vice versa in relation to budgets. It does not seem to have a lot to do with what happens for someone. Jo requires this, but I have got social services to pay for it, and because they paid for it was half the cost, but in reality, it is only half as good for Jo and if we had negotiated, we could have both paid half, and got a better deal for the person involved" (Rn3).

"I think people are being pulled, they are either health care or social care and nothing in between. It is ridiculous people have both needs and the amount of time people spend trying to define which service people fall into is unthinkable" (Rn9).

"There are fundamental problems with what social services and health are doing, based on my experience as a named nurse. With various people in agencies, we do get into service wrangles, which do break down into who has got allocation of resources, whose got responsibility for what" (Rn7).

" I just mean that there are barriers to me, where there are professional or interprofessional boundaries, and an obstruction comes up perhaps, where there are members from health and social care, because everyone has their own agendas within that. Very often it's the old adage of divide and rule" (Rn4).

Despite these tensions, the RNLD may intervene, using leadership to seek a review of proposed allocation of resources :

> *"Once someone is with us, we find that we are taking a lead on input, and they are actually inviting us to come along with various propositions, and we will find that they will either go along with that, or we will have to argue a case. There are occasions when we may be under pressure to admit someone, because theoretically we have a vacant bed. I have been involved in this and I have to make a case to service managers, in the absence of other team managers based on gender or need rather than an apparently available bed" (Rn 8).*

This might not always be straightforward. A key attribute on the road to collaboration is that of legitimate involvement or validity as a stake holder in the area of practice concerned. Shifting social policy legislation has in turn legitimised and questioned the presence of professional organisations for people with learning disability. The possession of "domain consensus" (Braito et al 1972, cited in Hudson et al, 1999, p. 244), that is permission to operate in a particular practice context, and claim to work with people, acts as the entry ticket to an "emerging network"(Hudson et al, 1999, p. 244). The process of entry may be problematic, and this has been the case for the RNLD (see chapter 3). Yet as Hudson notes, other professional groups who meet policy criteria for involvement may be reluctant to join:

> *"It is very complicated because a lot of people who have been in our services forever, well social services just don't want to know, because they say they are already being provided for. When it comes to money, well learning disabilities costs a lot it is long term, so they don't want more of those people, and when it comes to care management, it is up to social services to get them going because at the end of the day, they are the ones with the funding" (Rn9).*

6.3.5 People with Learning Disabilities

Despite the complexities of collaboration, the RNLDs in this study frequently stress the need for it, and express a desire to work through the tensions presented. Yet with nursing often

viewed as working to a narrow set of clinical competences and skills, and taking a role in the maintenance of current service delivery as part of the existing social order (Crowe, 1997, p. 60), the enthusiasm for change described in the data might be questioned.

One reason for the response, is the position of the client, who is used both to defend or justify forms of interprofessional relationships, despite the frustration of limited resources. Barr (1997, p. 1006) suggests that interdisciplinary teamwork, has brought about positive results for clients with learning disabilities and their families. Here strategies used to support the clients' needs are described (Category CL, Client):

> *"If the service user woke up in the morning and did not want to keep his two or three appointments for that day, that was his prerogative. My role would be to phone these people or facilitate him phoning them, it might also include his parents because the family dynamics are also very much a part of the picture with me acting as his intermediary, and passing on his wishes to those people and it was felt necessary to get all those people together in one room, to make clear that we were going to respect those wishes. The work is ongoing, there are still things to sort out, but it is sorted out by and large" (Rn7).*

These may include a shift in the role of the nurse, based on increased autonomy for the service user:

> *"There tended to be a duplication of effort for that person, and for that service user, we became part of the problem. It meant sitting down and saying who exactly are we talking to and why ? It might as a result of a multi disciplinary meeting, mean that certain aspects of care take a back seat. Another example having first done an initial assessment, we have been able to find an independent advocate, so a lot of the work I would have covered, I am now happy to let go of, because I feel it is more appropriate for an advocate to work directly with the service user. So no relationships are static, and because someone has been with us for six months, their needs may change dramatically, the dynamics of various professional relationships change constantly in that six months, and we would try and evaluate*

what is happening and make sure changes are made to continue to meet the person's needs" (Rn7).

Or taking on a professional advocate type role:

" The confidence and willingness to challenge and get stuck in for want of a better phrase, where we see practice or service delivery from other disciplines and even from our own, it has to be said, if it is not the best for the services group we are representing" (Rn3)
(Category CL, Client).

Participants' relationships with people with learning disabilities focus on the needs of the individual. Likewise when it comes to interprofessional practice, this knowledge and approach is applied to building relationships with professionals (From Category K, Claim to practice):

"You take more of an interest in people with learning disability as individuals, so I think you look at other people (professionals) differently, and as individuals, and not just what they do or they don't do, but because you are trying to develop relationships" (Rn1)

There is evidence of an integrated approach, that is a dual concern for clients and professionals, in operation to achieve outcomes for the client:- (From Category CL, Client):

"We have stood together as a team, to resist pressure as we see it, to compromise that level of service delivery. For example it might be in terms of refusing to admit a particular individual, who it is felt, might put others at risk, which we saw as our primary responsibility. The question was raised, well you are refusing that person a service, but we all stuck together and worked it out as a team from a best practice perspective" (Rn7).

It is interesting to consider the reason for this. Such beliefs are not unusual in expressed professional justification for practice, where meeting both the needs of the client and the need of the professional group are common. Alternatively it may be based on the assumption that people with learning disabilities need professionals to create change in their lives, as Aspis (1999) writes, " Disabled people with learning disabilities will always need to depend on non disabled people who are in positions of power" (p. 178).

Equally emphasis on relationships with other professionals could be as a result of the need to access resources. Networks are important because they offer access to resources, people, information and skills, hence the RNLDs ongoing engagement with building relationships, particularly if resources are in short supply. Here participants highlight the need for collaboration, noting the increased threat of marginalisation for people with limited power to control the allocation of funding for their care (Stainton, 1999, p. 141).(Category CL, continued):

> *"At the end of the day, it is because a placement may have been unsuccessful, and you have either got to create change for that person, or you have to find a new placement for them. It means good team working with Social Services and making sure we all do it right or inevitably some other solution will be found, that meets nobodys needs" (Rn9).*

For whilst defence of the professional role is present (Category VP Validating Practice):-

> *"It is not to say that in our team, we are totally united in approach, there is quite a wide diversity in approach and thought, but when it comes to fundamental things, we seem to be in agreement, and whatever our internal differences, which may be quite subtle when it comes to the fundamentals of service provision, we are fiercely protective of our remit. We might defend it at that level, rather than on the needs of the individual service user, at any given time to keep ourselves operating, to defend our remit for the future, we may make sacrifices in our working patterns, so that if changes should come about, we can state our case and demonstrate that we have made not sacrifices but commitment, personal commitment to making our service work beyond the basic call of our work"*(Rn 7).

The client group is described as the motivator for intervention and responses to team working (Category MC, Client Group as Motivator):

"Well a lot of it comes from training, most of us who are qualified had worked as support workers in various related fields before, so I guess most of us practise, it's a very conscious decision on our part, to want to do better for the service users we are working with" (Rn7).

"A one stop shop, a seamless service for the service user, so that the service user is not between health and Social Services, and having to see all those different people and go through all those different assessment packages using a range of tools, when all we are trying to do is meet the specific needs of an individual" (Rn8).

"At the end of the day, the driving force behind it, still remains for me the best interests of the service user, and in service development in general I guess" (Rn1).

6.3.6 Professionals in conflict

Even though practitioners describe team relationships in terms of benefits and outcomes for clients, in practice interventions may not always have such positive outcomes, and the participants are open about this. When service responses have been ineffective, or have not gone as planned, interprofessional relationships may come under pressure. Teamwork across agencies and with other professionals is presented as potentially divisive in a crisis situation. Participants explore these relationships below (Category C, Crisis):

"When we are working with clients, it is very rare that things are going well, so it is usually quite tense, people are quite screwed up, usually reluctant to see you involved, because they have actually failed or they see it as a failure in terms of the external support, they probably feel quite under pressure themselves if things aren't working"(Rn2).

"Crisis can make us and our colleagues very isolated and under pressure, and they don't appear to have the ability or mechanisms to enable them to make positive changes in service delivery that we can offer" (Rn5).

"It is very difficult, because when there is a crisis concerning a client everyone has their part in that crisis, so there are health parts of it, everybody is worried about the same thing, and blaming other people and it can be very difficult" (Rn6).

"Crisis can dash high expectations of working relationships, and you have to go away and think about how you are going to realise those expectations, or lets put all those hopes and aspirations on one side and forget about it, it does happen with folk and you have to refigure out what the big bad world looks like, so it can be a part of your practice. You expect social services to take accountability and be supported by senior managers, when the reality is budget and numbers, and this does lead to uncertainty in professional roles" (Rn4).

"When things go wrong, there can be conflict between social work and health care agencies, you need to try and remain impartial and work pro-actively, rather than deal from one place only" (Rn2).

One of the reasons identified, for conflict in teams, is that separate lines of management can create barriers in the achievement of shared objectives. Subsequently, there is a conflict between team loyalty and loyalty to the employing organization. Within this study, category T, Communication develops the inter relationship between individual professionals and how individuals work around organisational constraints. These reflections, indicate an acceptance of the complexities of communication, along with an understanding of the need for maintenance , to keep channels of communication open in order to change practice. Attention to relationships is once again present, Hudson et al cite Cropper (1995), saying that fairness, in both distributing benefits and in procedure are helpful in gaining a reputation as a good partner (Hudson et al, 1999, p. 250).

Here steps in the process of communication are described, as a new conflict management role

emerges (Category T, Communication):

"Traditionally with Social Services, they (relationships) have been strained, historically there have been problems, we understand that in a house where eleven staff are helping clients that there will be miscommunication and misunderstandings, but we try to make the best of things for people actually attending a service, and even in other services we use in health, there can be the same misunderstanding and communication breakdown, which causes the kind of resentments and again we have to try and move things on and avoid problems" (Rn 3).

"In terms of Social Services, the services we are involved with, often there are limitations. There is not always a chance to build up a rapport with an individual or a group of individuals, but if a problem arises and it can't be resolved then I will try and make an appointment to see that professional personally rather than letting things build up"(Rn3).

"I think there is a value in going along and meeting people, because some problems arise because you don't get to meet people, so it is quite good to go along to the social worker's office and look at a client's file, and you do also get a chance to meet people, speak to them. I mean sometimes there are meetings but they are exceptions, and only when there is a crisis, so it is good to speak to people on a one to one basis away from that sort of event" (Rn6).

" In the same way as you would use a different language to a social worker than in work with clients, it isn't helpful to be looking for scapegoats when things go wrong, but an honest discussion, maybe with some clearing of the air can only help in future collaboration with that person" (Rn6).

Uncommonly, a few participants voice a willingness to work through conflict, moving beyond an acceptance of its presence in practice, toward resolution. There is reference to conflict as a learning experience (Category T continued) : whilst taking on the conflict

management role is again significant for the RNLD in seeking effective interprofessional teamwork. The emphasis on relationship building as a key element of the process is also present:

> *"My understanding about people and how they behave is based on developing my own communication skills, and it is about relationship skills and showing and actually demonstrating to people that you are willing to be open, that you are not going to be precious or defensive, that you are going to share your knowledge and not shroud it in mystery which some people would like to do, and maybe the organization might encourage. Yes, actually demonstrating to people that you are going to be working together within the service. We have started writing out service intervention agreements which we are agreeing with people (Service Users), and then circulating to other people that are involved in commissioning so that it is sharing rather than keeping it hidden "* (Rn5).

> *"I think there are valuable lessons to be learned in terms of team-working, so I guess my personal experience across disciplines can work and work very effectively. My training, obliged me to take a fresh look at my workloads and beliefs and whilst I kicked out at some of that at the time, and still don't agree with some aspects, at least it did force me to have a look and then I guess consolidating that into my practice over the last year or so, trying to take the good from both sides to the point at which I can work effectively and learn from people, even if I don't agree with where they are coming from, because at the end of the day, the driving force behind it still remains for me the best interests of the service user, and in service development in general I guess" (Rn7).*

6.3.7 Endorsing interprofessional practice

Client need remains the driver for responses to interprofessional practice and is demonstrated by the majority of participants. The affirming category below, describes this affinity and an understanding of interprofessional working (Category A , Affirming):-

> *"It seems that the majority of professionals will be batting on the same wicket, and*

as a principle it clarifies the responsibility and the actions required and therefore means that the service user actually gets an effective service and the objectives are clearly stated" (Rn2).

"It is very much about trying to help other people see other perspectives other than a rigid health and social care divide, rather saying we are all trying to meet the needs of an individual that exist somewhere on a continuum and maybe if we can have some sort of constructive working relationship A/B has got to be better for that individual than wasting time looking for C. Some of the health professionals are really good to work with" (Rn8).

"A one stop seamless service for the service user, so that the service user is not between health and Social Services and having to see all those different people and go through all those different assessment processes using a range of tools, when all we are trying to do is meet the specific needs of an individual" (Rn5).

The intention of practitioners in the study is to practice interprofessionally and in doing so accept the pressures of interprofessional working. There are few explicit examples of negativity expressed despite role ambiguity in contrast to other studies of teamwork roles. Yet why should this be the case ? What circumstances have created a difference in position for the research participants here ?

6.3.8 Shaping professional identity

One of the reasons for the proactive stance toward collaboration, taken by the RNLD group in the study, may be to oppose the historical perception of the profession (Mitchell, 1998, p. 11). There has been a noted shift in the context of learning disabilities practice, together with the ongoing struggle for legitimisation in order to ensure their visibility and viability as a professional group. As Loxley (1997, p. 55) writes, "When the group identity can draw into itself attributes such as trustworthiness, expertise, wisdom, then it will acquire esteem and enhance the self esteem of its members"

Certainly marginalisation was present for some participants in the educational

experiences at pre registration level. Category Z, Negative Experiences, describes this:

> *"I think it was a disadvantage in some ways because you were with 10 people, out of 60 , for three years and because you knew you were going to be together for three years. For the first year you tended to stick together because you knew that you were going to be with these people for three years and then by the time you got through the first year you just knew these people and tended to stick with them because that is what you do and kind of not integrated much as you would have done with any other group"* (Rn8*).*

> *" Challenge was , I think social role valorisation mainly in terms of unconsciousness, because it is not an ideal widely entertained in nursing outside the RN (LD) philosophy of nursing. We are concerned with impact on the client group. If others in our training were more conscious of the effect their response might have, things might have been a lot easier" (Rn3).*

> *"Lots of the experiences were difficult. We were constantly in the minority" (Rn2).*

Whilst in practice, since qualifying, the threat of marginalisation has been experienced by participants. Category DE, Professional Devaluation acknowledges this :-

> *"They don't seem to recognise the problems we have got, when they are hassling us for a place" (Rn1).*

> *"It seems to be moving away from the need for learning disability nursing and the skills they have just don't seem to be recognised. I don't know. The feedback you get, the sort of panic, there won't be a need for them. It makes you feel very devalued, it is not always (Community Care) a positive thing for nurses" (Rn3).*

> *"It doesn't seem to be being created by learning disability nurses, either, defining their role or whatever, it seems to be being created by people who don't understand the role"(Rn 3).*

Yet there is not much sign of a retreat from the RNLDs here. The openness from participants in acknowledging marginalisation, may in itself be an example of the reappraisal of the RNLD role. This activity can be partially explained as a result of current social policy, and the position of social work agencies as lead provider of assessment and care management for this group of people. Changes in the states role in welfare provision and its impact on service users and professionals alike, is a key factor. Emphasis on the meeting of individual rights, have shifted the focus of intervention from the paternalistic to the autonomous (Stainton, 1998, p. 136). Further whilst services still function on a "collective welfare principle" (Stainton, 1998, p. 137) that is, what is best for the group of people with learning disability, this is slowly changing. As the Government's strategy document "Valuing People" (DOH, 2001) is implemented, the focus on individual packages of care may gain further momentum. In practice enabling the person with learning disability to not only define their need, but ultimately how those needs are met (Stainton, 1998, p. 138). This has significance for the RNLD role, a group which had in more recent decades championed their role as the assessor and provider of need across the health and social care spectrum.

In seeking a new identity, a willingness to shed the paternalistic elements of the old style RNLD, along with a recognition of their skills and knowledge in modern practice (Sines, 1993) and teamwork are viewed as significant. Making this contribution visible may be viewed as an integral part of the process of change. Here participants describe their emerging practice role in teams. These vary from blurring the boundaries :(Category K, Claim to practice) :-

> *"I still blur the roles if I know I can do something and I know the social worker is going to take ages to do it, but I will be up front about it" (Rn 5).*

> *"We would be trying to help people with needs across health and social care. We have occasions where people from social care may feel that we are intruding into areas that aren't ours, and people make it clear that they aren't ecstatic about the prospect, but we will do it anyway" (Rn2).*

Or remaining within the contemporary RNLD remit:

"It is about being clear and confident about what your role is, job description, professional accountability and that will enable you to make your point and carry it through" (Rn4).

Through to a form of holistic advocacy :

"The confidence and willingness to challenge and get stuck in, for want of a better phrase, where we see practice or service delivery from the disciplines - and even from our own, it has to be said of it, is not the best for the service user group we are representing" (Rn7).

"We tend to get as involved as we possibly can- so we are always there, so everybody sees us, we don't disappear" (Rn1).

"Yes, it's nursing driven but not within the strict confines of a specific aspect of nursing -not just physical or mental health needs, it would be making their care or to help them put their own case in terms of their social needs as well" (Rn7).

"By and large you can keep your feet on the ground and say we are here to help" (Rn2).

There is also a degree of assertiveness and positivity which indicates that they are confident that their role is both desirable and viable within the contemporary context of care (Theme category D, Professional Recognition):

"But then learning disability nurses are quite set apart from other nurses, and the focus again is different. Although if you are a general nurse you have got to have positive feelings towards people to do it, but its still very different to go and work in a general hospital where the whole atmosphere and emphasis is not about people as individuals. Plus working in the community makes necessary a different set of links with colleagues, and brings out a whole lot of new skills" (Rn1).

"I think what we have got to offer is very important, and there are ways of making

them not like traditional nurses (The RNLD) and still having those skills, having more of a social work role or assessment input, together with having that role we've got, which is I think unique to learning disabilities nursing" (Rn5).

"You highlight issues they would perhaps rather not have heard of, and we can be a pain in the arse at times for that" (Rn2).

"We aren't social workers, we are not nurses in the traditional sense, to use that expression so we are neither one or the other, but we do carry out social care and clinical care and to a small degree mental health work albeit not using mental health services, as access is limited for this group of people, so it is three areas" (Rn3).

6.3.9 Confidence in Practice

This largely confident professional identity, does not dwell on negative elements of current practice. Neither is it situated in a professional utopia. Loxley (1997, p. 54) suggests that where group identity is based on perceptions of negative characteristics, held by other professionals, if the members of that particular group accept these, "then the groups self esteem will be low and it will be judged to be weak". Further, participants belong to the nursing profession in terms of professional accountability, a group which Jolley (1995, p.95) describes as oppressed, sharing the group traits of a lack of self esteem and a lack of pride in nursing (Jolley, 1995, p. 95). Referring to the predominantly female makeup of the nursing profession, and nursing's link with femaleness, she continues to suggest that professional socialisation, leads to compliance, submissiveness and dependence.

In contrast, participants in this study did not refer to gender as an issue in collaboration or in their descriptions of professional practice roles. However it was noted in a description of the appropriate meeting of client need. Historically, the RNLD nursing group unlike their acute sector counterparts, have not been predominantly female (see Chapter 3). Whilst the difference between the acute or hospital nurse and the RNLD is clarified by participants:

"But then learning disability nurses are quite set apart from other nurses, and the focus again is different" (Rn 1)

"Yes, it's nursing driven but not within the strict confines of a specific aspect of

nursing" (Rn7)

"I think what we have got to offer is very important, and there are ways of making them not like traditional nurses"(Rn5)

"We are not nurses in the traditional sense, to use that expression"(Rn3)

"I think it is because you don't go in as a nurse, you don't go into a client and deal with one issue" (Rn2)

"A lot of traditional nurses, if you asked them what they would do in a team, they would just stutter" (Rn 3)

" In nursing you are always in a different group, yet you can and should see things from a health point of view"(Rn9)

A broader role for the RNLD in contrast to that of the acute nurse, is set within a positive and secure professional identity , which seeks to embrace a holistic advocate role with that of change agent, described here (from Category R, Contemporary Role):

"You can't just go in, do an action or whatever and withdraw, you are looking for progress in the longer term, for more permanent change for an individual" (Rn1).

"We are the people bringing about action, we seem to be the people doing that" (Rn1).

"We are underneath it all making change happen" (Rn3).

"I think what they (RNLD) have to offer is very important. and I think quite unique to learning disability nursing . Yes we are looking at their (People with learning disabilities and their families) needs, their immediate needs, caring for them, but we

are also looking to the future and to make changes when and where they are needed (Rn4).

Such responsiveness to change has occurred, despite a less predictable application of knowledge and model of intervention The client group offered resources, has changed, with the emphasis on meeting the needs of those whose need is greatest, predominantly those with more severe learning disabilities. The model of provision is no longer medically driven, as long term support is provided by Social Services and health. These participants describe educational experiences that have in part provided learning opportunities, which reflect this contemporary world (Category X, Skills and Knowledge gained):

"I don't have a problem with saying in a case conference that I don't agree with something because you are kind of bombarded with it for three years that that is what you are expected to do and in the end it is really not a problem any more. So I am quite assertive like that and it is not a problem" (Rn8).

"Definitely education, without it I would not have been able to develop in the same way. Our placements were in a variety of professional areas, you learnt that different people have different perspective on a problem especially on family placement ,you would see a community nurse coming in you didn't just see the CNs perspective, you could see the family's perception families might want more practical help, one person has a set. of ideals and the other has different set and never the twain shall meet unless someone has an understanding"(Rn3).

"From doing the course, I have gained experience of working in hospitals, the medical side of things, dealing with doctors in away that nurses are supposed to do, in a way that gets results for people. In Social Services you wouldn't learn how to get to the consultant you would be lucky to get past the GP" (Rn4).

The contribution of education to personal growth is explored Category W (Develop a Position):

"No biggest lesson taught was how to get results and how to play the system, outside the training, it wouldn't happen you wouldn't know how to get effective care, before

training I was too much of a steamroller in terms of attitudes and getting things done, now I am more impartial" (Rn4).

Whilst the value of the practice context is noted, in common with other studies which confirm the value of the educational programme and educational environment (Fitzpatrick et al 1996, p. 506):

"The other thing is you meet lots of different people over a short period of time, in 3 years you have met lots of different people in lots of different placements and you are used to asking questions, so that is useful and just being in lots of different places and knowing what other professionals do and about their role. It is more than just a personal thing I think" (Rn8).

"I suppose the whole course gave me the opportunity, there was lots of discussion and lots of discussion groups and people will have strong views that are not the same as yours, and you will have strong views and that is kind of what we ..... and you get more confident about saying what you think rather than going along with or not saying anything because you feel a bit stupid when you are the individual person who feels like that, and I don't" (Rn8).

These may be a factor in the ability of the RNLD to function securely in team settings . For ultimately, the perception of RNLDs as members of a group of nurses who are oppressed professionals may need reassessment. Whereas acute nursing is responding to the NHS modernisation agenda, it remains largely hospital centred, with emphasis on medical treatment (Payne 2000, p. 42).

In community health, despite the transfer from primary care groups to primary care trusts, the major components of intervention, that is the actual face to face contact with clients or patients, still centres upon short term treatment, for the majority of nurses. Further community involvement of other community and primary care nurses may be limited by attachment to a particular health centre (Kelly et al, 1998, p. 174) Thus the gap between the roles and the practice domains of the RNLD and the RN remain, despite the significant emphasis on health for the RNLD. As Payne writes (2000, p. 43) traditional models of interprofessional working based on primary care teams, have been replaced by a set of more

complex relationships, requiring different leadership at different times. In practice nurses may be leaders when there is physical long term care to be provided, as in the case of people with learning disabilities. Such interventions are likely to be in a wider geographical area. Comments from Category D (Professional Recognition) acknowledge the development of new roles:

> *"As we get more involved with people that have complex health needs, then we have become more valued because other people don't have the expertise to deal with it" (Rn1).*

> *" I look to learning disabilities nursing to achieve and create change its more powerful. It 's not more powerful in terms of policy recommendations , but if you are into the job, not the big cheese, and come into this (*RNLD practice*) to actually help folk and create individual changes, then stick with nursing" (Rn2).*

> *"When I went into it I wanted to become a nurse and then take it from there and I could see lots of real positives about doing that and making changes for people and that's what I wanted to do" (Rn 7).*

> *" Yes the way I would sum it up straight off the top of my head - a firm philosophy eg SRV and the seven service accomplishments comes first, then empowerment, a real issue not as a buzz word, which is all about giving people self awareness, the skills and the motivation for themselves, power should be equal across professionals and clients in a team. A firm philosophical base to improve the lives of people and I think that is it also taking care of any service need, medical need and physical health need" (Rn3).*

An understanding of these new roles and subsequent role security is illustrated by a readiness to develop a leadership role for the RNLD. Moore (1999, p.25) writes of the skill of the RNLD in dealing with the deceptive health and social care divide, and their ability to overcome marginalisation. Boulter and Cook (1997, p. 13) place the RNLD and their experience with continuous change as ideal transformative leaders, whilst Burns (1978) describe the characteristics of transformative leadership as appealing to higher ideals and values. Zalesnik

(1989) includes a sense of vision and a strong sense of conviction.

In a wider organisational context, Hudson et al (1999, p. 251) refer to the key influence of the 'reticulists' in interagency working. Hudson notes that a significant part of the reticulist role is operating from a sound position of power and legitimacy. In this study (Category E, Professional Empowerment) participants describe their use of power:

"It becomes easier to say it the way it is, and not pussyfoot around things or flower things up. You do have to explain yourself clearly all the time, and say sorry this is the way it is, we can't do this or we can't do that" (Rn1).

"Then you won't take a lot of shit, you will stand up for people in the most supportive way you know, no matter what, so that in terms of advocacy you have that education, that knowledge, in order to defend your argument" (Rn2).

"We (The RNLD) carry out a multitude of roles, very skilled people equipped to do a lot of things. There is increasing clarity over our role from within and from the outside world. But I think it had to start with us" (Rn3).

"We (The RNLD) are getting lots of people who haven't had to work in hospitals and long stay wards, and in learning disabilities we have had to work to ensure that the passion that had to be there is built upon. Community care and work still needs creativity and a concern with people's rights and that is what gives a focus to our practice" (Rn7).

"Learning Difficulties (Nurses) tend to be more of a really, huggy, warm, touchy feely sort of folks and less... (silence) they're not less professional but less abruptly professional, they don't have to hide behind anything, if you know what I mean" (Rn2).

"From relationships to environments, to developing trust in others, developing participation skills, social care schedules, health needs, the whole shouting match, we are used to fiddling and fermenting in those and helping others to do so" (Rn 3).

This confidence in practice suggests ownership of high levels of motivation and vision, challenging the marginalised status of the RNLD group Where lies the key to the shift in practice identity? Maintaining a vision is integral to Thomas and Velthouses' (1990, p. 676). empowerment model. How individuals attribute success and failure, the extent to which outcomes are internalised and the impact of the environment are all critical factors. Therefore the skill to recognise what is important as compromises are made, and how the individual professional perceives this process, may impact on performance satisfaction and levels of personal power. Having a vision also requires a constant focus on success and avoidance of failure. As motivation increases through this emphasis on success, an individuals levels of confidence and expectations of competence are expected to increase (Thomas and Velthouse, 1990, p. 676). Emphasis in practice is on people, those with learning disabilities and other professionals. Consequently it would seem that having knowledge, expertise and experience in the teamwork arena pays, enabling goals to be set, and a critical understanding of what can be achieved. Likewise, having a level of self awareness to face up to the realities of practice without lowering standards.

Criticism (Category J) illustrates the need for skills in challenging some professional responses, and the motivation of participants to do so:

> *"Mental Health doesn't always seem to apply, are not strident about their client care, unlikely there is going to be lots in the literature on why mental health nurses deviate from their role but often more about protecting their own sanity, and I think this has to be explored, and it may come out in collaboration" (Rn2).*

> *"Social Workers can be unintentionally manipulative when seeking a solution in a difficult situation. It is up to us to recognise this and work through it" (Rn1).*

Whilst Category Q (Questioning Practice) clarifies the need for attention to the professional contribution of others:

> *"You have to be very clear about what their legal obligations are, they have to know the Children Act, to know what they have to provide, and have to work with you. So*

once you can do that it is fine, it is just reminding them what their responsibilities are" (Rn8).

"To gain a good working relationship, practice action is required. This may be a follow up action, or it may be a challenging action, that is not being afraid to have an exchange of thoughts with someone. If a person is closed up, so doesn't chase up what is happening, then what they are doing won't work, won't be so successful " (Rn7).

"Now I would say working together is effective if you are able to develop a relationship with someone. If you can value their professional expertise and feel OK when its' needed to challenge views or a suggested input" (Rn4).

Also insights into strategies for building interprofessional working relationships convey a sense of adaptability, context expertise, interpersonal power and awareness (Category P, Interprofessional Knowledge):

"The(MY) value base remains the same , but how you would convey the message would be different. There is no point talking to a psychiatrist about social care being a primary issue and you have to, I don't know whether we do it to ease, to facilitate speed of understanding or whether we do it to show that you are almost a buddy of theirs and it's safer to talk by using their language, I guess it's more about developing the relationship with them quickly by using their language and putting them at their ease and finding some sort of common ground" (Rn2).

"I think that sometimes there are things that you really need to ignore about other professionals and let them go in the case of joint working, and I have also realised that it can make a difference having a colleague from another profession working with you. It offers support and you can support them as well although when you know who someone's social worker is you may be relieved, or you may think oh my god ...it is not going to help much" (Rn5).

"Developing empathy and understanding I am not sure that this necessarily comes naturally, I think you have to think about it. I mean we all get cross with people and it may be the fifth time you have had to sort it out that week. Resolving a difficult situation, won't come from bringing anger about it, into that communication, and there isn't time to be angry with people" (Rn 6).

The positive professional identity of the RNLD described here might suggest that for participants in this study, a change in professional culture and performance is taking place. This change in outlook may be the result of, and response to interprofessional working . The RNLD may be demonstrating some of the skills of a practice based reticulist, and change agent, gained during an ongoing period of professional growth. The key to this being the RNLD response to and use of power, amidst a dialogue centred on the multiple needs of people with learning disabilities, and conditions for effective team working. These individual experiences, have shaped responses to interprofessional working. A product of tackling conflict, acknowledgment of role ambiguity and role blurring and an awareness of the changing context of practice, this knowledge has resulted in a creative response to power and collaborative practice in the teamwork setting.

6.4 Reflecting on practitioner responses

This part of my research journey, has been both exciting and exhilarating, and following data analysis it is interesting to reflect on the findings that emerged from the dialogue.

The most significant in relation to the overall findings was the strength of feeling of the respondents in terms of creating change for the client group. In the earlier questionnaire results (Chapter 5, section5.9.4), I had questioned the motives of professionals who might hide behind professional defences through role assimilation, in order to offer an idealised vision of practice. In contrast, here participants were out with all guns blazing offering a range of strategies to continue their intervention or to ensure the intervention of others. I had not anticipated such powerfulness or the level of comfort that participants expressed in taking on this role, despite a number of barriers at national and local level explored earlier in the thesis. I felt inspired to capture these qualities in some way that was beyond the descriptive.

Alongside this willingness to blur boundaries and remain involved in a particular situation, participants dialogue expressed a dazzling level of confidence in the interprofessional

setting. I interpreted this from the participants' description of creative practice level solutions, which were underpinned by a great deal of informal knowledge about interprofessional working. I also noted that this commitment seemed to be based on reality rather than ideal or perfect practice, which was confirmed by the participant driven exploration of and acceptance of crisis as an integral part of their work.

The extent to which participants accepted crisis work was in itself to be expected given the nature of service delivery and a client group with profound learning disability. However it was the maturity of responses to crisis in the data that further affirmed my feelings about what this group of people could offer to others in terms of a blue print or model for interprofessional practice. Responses and solutions were largely proactive, reflective and with an absence of hostility or cynicism towards the other professionals in teams. Participants' focus was centred on handling the conflicts that crisis could create, setting in place actions to sustain interprofessional relationships and acknowledging their own power in that process.

I felt there was a great deal of energy in participants responses with an absence of reliance on "we have always done it that way" as a rationale for practice in the interprofessional context. This movement or receptiveness to new contexts and practice solutions, substantiated in the data, needed to be captured in some way again drawing me back to the need for a conceptual framework.

During my reflections I was aware that the data offered both the practitioners' description of practice, being an account of what interprofessional practice was like, and a number of good practice guidelines founded on the practitioners' experiences. I was motivated to further analyse the data, developing an holistic framework for practice, which would assimilate participants' activities in practice (the descriptive) with the prescriptive, that is their thoughts on how interprofessional practice should take place. This next stage of data analysis is presented in chapter seven.

6.5 Shaping conceptual thinking

The individuals critical understanding of the context from which they are generated, represents a different form of knowledge, or personal theory in relation to practice. This personal, experiential knowledge has resulted from the ongoing iterative relationship between the participants and their data, and my role as researcher. The interaction has provided an answer to the question "How professionals in the field of learning disability view

interprofessional practice" along with the potential for a further layer of analysis. This will capture practitioner knowledge, confirm its' meaning through the literature and seek congruence across the emerging concepts as part of a theoretical framework for practice.

Chapter Seven

The Conceptual Framework

In chapter six a descriptive analysis of data presented a set of key roles, practice focused knowledge and teamwork strategies, developed from research participants' accounts. Here in chapter seven, these critical elements of participants' personal theory are used in the construction of a conceptual framework. The contents of the framework offer the evolutionary components of a model of interprofessional practice, to be used in the long term support of people with learning disabilities. Throughout the development of the framework, the nature and generation of empowering practice is explored.

7.1 The Conceptual Framework

The term conceptual framework is described by Fawcett (1995, p. 2) as a set of abstract and general concepts and the propositions that integrate them, to create a meaningful configuration. Other terms such as conceptual model, paradigm and disciplinary matrix may be used synonymously. Concepts are words that describe mental images of a phenomenon. Fawcett suggests that concepts in a model are generally so abstract that they are not limited to any particular group, situation or event (Fawcett, 1995 p.2). Propositions are statements that link or describe concepts.

Conceptual frameworks may be used to develop grand theory which remains largely abstract in nature, and middle range theory which spans abstract ideas and some more concrete ones (Fitzpatrick and Whall, 1996, p.19). Here the framework is representative of practice level or micro-level theory, the key difference being that its purpose is less abstract with an immediate application to practice. The use of a general grounded theory approach has underpinned the frameworks development.

7.2 Conceptual Frameworks in Learning Disability Practice

Although widely used in nursing practice, in learning disability nursing there has been limited development of conceptual frameworks. Jukes (1996, p.293) has explored the application of advanced practice in nursing in the learning disability field and Duff (1997, p.703) notes the lack of use of nursing models in the practice setting of learning disability. Biley and Donlan (1990) and Priest and McCarthy (1993) have developed practice driven tools for community nursing practice, with Biley and Donlan (1990) suggesting that their tool remains as a starting point for a model. Duff (1997, p.703) notes that neither of the former practice tools is research based. Moss, Bouras and Holt (2000, p.97) adapted Thornicroft and Tansella's matrix model (1999) designed to guide the development and evaluation of mental health services in the general population, to people with learning disability.

More recently Jukes (2001) refers to the use of theory by community learning disability nurses, noting Owen's application of Newman's model of nursing, in assessment and intervention (Owen, 1995, p.752), and Dale and Elliots' development of the health wheel in the assessment of carer need (Dale, and Eliott, 1999, p. 52).

The sparsity of models and frameworks may be an example of the RNLDs lack of identity with other strands of nursing, where models are likened to the medical model (Jukes, 1996, p.293). On the other hand it may be as a consequence of the ambiguity that has historically surrounded the RNLD role and its boundaries, and the challenges this has presented for practitioners within the profession.

As yet there are no conceptual frameworks in use specifically in social work practice with people who have a learning disability. Although Fraser, Richman and Gallinsky (1999) have developed a conceptual framework for risk, protection and resilience that may have some wider application in the field.

7.3 Conceptual Frameworks in Interprofessional Practice

In the literature of interprofessional practice there is an increasing concern with the nature of interprofessional knowledge and theory. This is represented by Rawson's (1994, p. 41) mathematical 'the additive effects model' and the 'multiplicative effects model' of interprofessional practice. Rawson's models use mathematics to indicate two alternative models of interprofessional practice, one based on each profession adding its own particular contribution and the other in which interprofessional working is seen in a gestalt vision (Rawson, 1994, p. 41). Rawson also uses Set Theory (Smith 1992) and geometric patterns to

explore inter-relationships and boundaries in interprofessional work. Rawson's work is largely abstract theory and is not designed to offer a practice level formulation or model.

Loxley (1997, p.78) offers a conceptual framework for collaboration, using systems theory, social exchange theory and co-operation theory all founded on theories of social interaction. The model addresses social structures, issues of power, culture and values at one end of the process of interaction, with core skills in assessment, building structures, managing processes and evaluating outcomes at the other.

Hudson et al (1999, p.233) explore theory and research to develop a theoretical framework for collaboration in the public sector. Drawing on a wide range of disciplines, the model offers ten collaborative components and associated factors which are largely features of organisational level activity. At present there is no conceptual model centred upon practice intervention itself, although Loxley's model is designed to assist practitioners and educationalists. As Loxley writes "the framework for collaboration does not offer a curriculum, but suggests the questions to which answers must be sought and action related" (Loxley, 1997, p.88).

7.4 Stages in the Development of this Conceptual Framework

In the previous chapter, a descriptive data analysis was undertaken. Morse (1997, p.175) observes that "Often the descriptive portion of a study is reported in a separate section prior to theoretical development. Such a strategy provides a means for the reader to appreciate the context and the data prior to the presentation of theory." (Morse, 1997, p.175).

Here the main focus of this chapter is theory development, and the chapter deconstructs some of the descriptive elements in chapter six and presents key concepts to drive best practice and underpin the framework recommendations. Figure 13 maps out the stages involved. The framework has both a descriptive element in that it captures what practitioners do in the interprofessional practice context. Additionally the further development of concepts and subsequent theory is prescriptive in that the analysis has also involved an exploration of how practitioners think interprofessional practice should take place. In doing so the framework offers a guide for good practice in the interprofessional setting.

Getting to this point, has involved the researcher further exploring the categorisation from the descriptive analysis of data. Alvesson and Skoldberg (2000, p.28) write that one of the tactics used in grounded theory is to find the core category or the central concept around which all the others revolve. By doing so, the key to the theory is gained (Alvesson and Skoldberg,

2000, p.28). I have also noted the concerns of some theorists such as Rodgers (1989, p. 331) in relation to the reductionist nature of some methods of concept analysis used in nursing. Rodgers (1989, p.331) whilst noting the contribution of Walker and Avant (1988) argues that the emphasis on constructing borderline cases, illegitimate and invented cases in relation to a particular concept, serves only to isolate it. Alternatively Rodgers (1989. p.331) suggests it may be more useful to focus on inter-relationships and the changing nature of concepts. The approach presented in figure 13 is guided by Rodgers (1987) in that the concepts explored are evaluated in relation to their resemblance to a particular phenomenon, rather than in strict correspondence (Rodgers, 1989, p.332).

A series of core categories has been developed from the data, and integrated to develop a set of inter -linking characteristics which form the preliminary concepts (Part one). I have been careful not to arrive at a list with no empirical base, including only those characteristics derived from the data (Dey, 1999, p.60).

Afterwards, literature from interprofessional practice, learning disabilities and other related areas, has been examined, identifying positive and negative relationships between my interpretation of the meaning or attributes of concepts and other research findings (Part two). Through this exercise, the components or characteristics which will form the theoretical framework are identified (Part 3). Whilst a set of attributes for each of the concepts is presented along with case examples from the data (Part 4). To further clarify the concepts, the process of identifying antecedents and consequences for each is presented, in a further affirmation of what the concept boundaries and meaning are in this framework (Part 5). Finally the interrelationship between concepts is evaluated for compatibility (Part 6). During the process, the logical connections between propositions made (Fawcett, 1995), are presented, taking account of the need for coherence (Morse, 1997, p. 182). Finally the selected concepts are produced as the conceptual framework prototype in a theoretical model.

7.5 The approach taken and the researcher

During this process there have been moments when my own beliefs have needed exploration, for example when I have been drawn to or dismissive of a particular concept or framework component. In particular I was keen to include the concept of expert and felt very cynical about the current use of the term empowerment in everyday practice. These terms reflected my views about learning disability practice and in human services in general.

I had a strongly held intuitive belief that the participants in the study were experts.

However in the process of concept development I was to realise that this was not yet the case for some aspects of the concept. By staying close to the data and taking note of the antecedents and consequences developed, I was aware that there was no logical elaboration of the concept possible (Glaser, 1978, p. 64). Therefore even though I may have felt that the participants were experts, following grounded theory principles ensured that I didn't create my own framework component 'expert'. Instead I found that in comparing antecedents and consequences of the term expert in a range of contexts it was evident that some essential elements were not present. Dey (1999, p.61) cites Glaser (1967, p. 64) who notes that it is the operational meaning of a term that counts. Offering the concept of social loss as an example Dey (1999, p.61) notes that this would be specified in terms of ways in which nurses respond to patients. Therefore the use of the term expert could only have been included if the responses of other professionals and policy makers toward RNLDs reflected this.

Equally whilst there were many characteristics of the concept empowerment in the data analysis, there were also other characteristics related to disempowerment and an acknowledgement of power differences both for participants and service users. However an exploration of the concept empowerment indicated that the antecedents and consequences of empowerment were present. Thus exploration of the consequences of professional action or inaction ensured that the concept was included, despite my cynicism about its' use in a rhetorical sense within organisations and services.

Dey (1999, p. 62) discusses the meaning assigned to individual concepts within grounded theory. He suggests that unless concepts are defined using some consistent criteria, there is a danger that in the theoretical framework, the stability of concepts will be lost along with coherence. In other words Glaser's (1967, p.64) concern for flexibility in terms of concept meaning could lead to fragmentation if and when the conceptual framework is generalised. Throughout the concept development I have responded to these concerns by defining flexibility as an openness to the likely meaning of a concept. Additionally in asking questions in relation to the meaning of a concept or of aspects of the data I have avoided defining a concept in advance of analysis and seeking data to fit. Rather a set of practice characteristics from the initial data analysis has been used to identify potential concepts. These have then been explored. Therefore whilst a consistent approach to the concept development has been taken, I have found Glaser's views on flexibility helpful in terms of exploring the potential meaning of the data and in the definition and interpretation of the concepts within the framework.

Part One	From stage one, the descriptive analysis to the conceptual. A set of Practice Characteristics drawn from the categories and descriptive data analysis are used to identify the proposed concepts
Part two	These proposed concepts are explored with the available literature, similarity and difference in meaning is explored.
Part Three	Clarity of meaning of proposed concept is outlined for each individual component of the framework
Part Four	Defining attributes and case examples are presented to define concepts in this framework
Part Five	Antecedents and consequences further refine the boundaries and meaning of the concepts
Part six	Inter-relationship between proposed concepts (compatibility, congruence) is explored

Figure 13. *The process of Conceptual Framework development*

7.6 The Framework Concepts

7.6.1 Concept One: Contextual Socialisation

7.6.1.1 The Context of Practice

In the descriptive analysis, participants provide a detailed portrayal of the situation and environments in which their practice occurred. The political and organisational context of practice was explored, with attention given to both the facilitating and inhibiting elements of current social policy at national and local level. This knowledge was not offered in isolation, but was an integral part of their experience in practice and in teamwork relationships. The following categories, F: Role *of Health Professionals,* H: *Contemporary Role Social Care,* Y: *Role Shift,* B: *Boundary,* G: *Control of Resources,* explored this inter- relationship between individual professional practice, the role of other professionals and the constraining and liberating elements of agency / organisational legislation and policy. Collectively, these descriptions result in the following practice characteristics:

7.6.1.2 Practice Characteristics

Creating team working networks with other professionals in health and social care, in a range of settings.

- Ongoing re-clarification of the role of professionals in social care, particularly social workers. The significance of professional boundaries and a desire to recognise the

positive elements of reshaped professional roles.

- Practicing within an ambiguous context created by social and health care agencies being both accountable for the welfare of people with learning disabilities, and constrained by resources, which may inhibit action.

- Operating to meet desirable outcomes and change for clients within an environment centred upon protecting rather than challenging organisations.

This set of challenges and tensions suggest that participants paid a striking level of attention to the context of practice, be it political, social policy, organisational/ agency or professional and interprofessional. The significance of context as a vital contributor to effective professional practice is central to their strategies of action.

7.6.1.3 The meaning of context

Context is defined by the Shorter Oxford Dictionary (1973) as firstly, the parts of something written or spoken that immediately precede and follow a word or passage and clarify its' meaning. Secondly as the circumstances relevant to something under consideration Websters International Dictionary (Webster, 1976) describes context as from the Latin, contextus being connection and or coherence. Roget's Thesaurus (Kirkpatrick, 2000) offers the following synonyms, situation, circumstances, conditions, factors, environment, meaning, spirit and substance.

In health and social care, context may be used in the literature to describe the physical place in which practice occurs. Alternatively context is perceived as the environment for clinical treatment. A more developed meaning may be that of context as the social, cultural, political factors that are in operation external to the person (Dunn et al, 1994, p.595). Additionally context may describe the external organisation and more abstractly the influence of ideologies, values and philosophies. Researchers describe research text in *con*text that is its external sociohistorical weave of connections (Skinner 1986, Phillips and Brown, 1993). Websters Dictionary defines contextual as in relating to, determined by or conforming to context (1976). Where context itself is explored, the overriding theme is the lack of attention to the context of practice. The focus is centred on debates and research findings linked to the meaning of context, and, or the dangers and consequent implications for practice of ignoring contextual issues. Molloy and Cribb (1999, p. 421) write of the importance of the social / institutional context within the remit of health care ethics. They argue that instead of viewing contexts as mere background constraints they should be an integral part of the remit in terms of ethical concerns

in health promotion, and the constraints on practice that these contexts create for professionals need to be understood better. Only through a more detailed understanding of contexts and the structures and cultures of care can ethics be properly debated. Researchers such as Gates (1990), Carr (2001), and Mcleod and Machlin (1998) have investigated the environment of practice, whilst Benner (1984), Mackey, Burek and Charkoudian (1987), Meyer (1989), Rodwell (1990) Gutheil (1992) Guteirrez et al (1995), and Crowe (1997) have explored the context in relation to conflict creating practice situations in health and social care.

7.6.1.4 The Neglect of Context

The literature relating to the context of practice intervention, suggests that it is a neglected area of concern for some professionals working in health and social care settings. However it is paramount to good practice when key knowledge of context and its impacts are essential. Knowledge of the context of practice may be a critical factor in empowerment of service users, professionals and organisations alike, playing a crucial role in the management of the change process, be it at national or local level. A link between expert practice and knowledge of the context of intervention is also suggested.

7.6.1.5 Participants and Socialisation

The second part of the concept contextual socialisation is socialisation. The Meaning of Socialisation is defined in Websters dictionary (1976) as follows: the action or process of making socialist, the state of being socialised, and the process by which a human being beginning at infancy acquires the habits, beliefs and accumulated knowledge of his society through education and training for adult status. The Oxford Shorter (1973) dictionary places socialisation as from socialise which is to render social or belonging to a community of some kind. The concept socialise is defined as to participate actively in a social group, enter into or maintain personal relationships with others. Roget's Thesaurus (Kirkpatrick, 2000) does not offer any words that are synomous with socialisation. Jarvis (1983, p. 88) describes it as "the process by which the world of reality is internalised and becomes subjectively meaningful." Socialisation is distinguished into two stages, primary being the process of socialisation in childhood, formally provided and orientated to adulthood, where secondary socialisation the process of being socialised into wider society occurs. Socialisation into the world of work is a crucial part of secondary socialisation, whilst professional socialisation encompasses the development of a specific knowledge skills and occupational identity, characteristic to that

profession (Du-Toit, 1995, p.168). Part of the process of socialisation into a professional group involves the internalisation of values and norms held by the profession, and making them a part of ones own behaviour and self concept (Du-Toit, 1995, p. 168). However as Abramson notes, each professional group socialises its practitioners differently (Abramson, 1990, p. 46) in terms of language, professional roles and models of intervention.

From the literature of health and social care, research into socialisation has included the areas of Professional Socialisation, (Hawkins and Ewens, 1999; Fitzpatrick et al 1996; Hey, Minty and Trowell, 1996), Socialisation and Interprofessional Work, (Huntingdon, 1986; Bruni, 1997; Taylor, 1986; Hudson, 1999), and Socialisation and Power (Pietroni and Pietroni, 1996; Crowe, 1997).

7.6.1.6 Contextual Socialisation: Defining attributes

When practitioners are contextually socialised, they hold the following attributes: knowledge about the context in which they are practising, based on informal and formal theoretical evidence, and the generation of questions related to the specific context. Furthermore they have also developed skills in balancing more than one professional view of that context, whilst maintaining a core area of knowledge related to learning disability practice. They are able to work with ambiguity. White (1977) describes contextual socialisation has experience of the political structure, cultural elements, the family, job, organisation and local community. Here White's definition has some commonality with the interpretation in this framework, except in relation to the impact of the family. This would be addressed with reference to the impact of context on the service users' family situation as opposed to the professionals own family circumstances.

7.1.6.7 Case Examples Of The Concept "Contextual Socialisation

Examples from the data illustrate the defining attributes of the proposed concept.

> *"You have to be very clear about what their (Social Workers) legal obligations are they have to operate within the Children Act and the legal frameworks of mental health. Once you can be clear about that it is fine. There are times when you have to work across teams and again most of that is with social services"(Rn4)*

Rn 4: This example incorporates knowledge of the context of practice, in this case practice with children and in mental health services as well as in learning disability practice. The policy context is referred to, which involves legal and statutory responsibilities. Knowledge of the role of other professionals is present, as is experience of working in ambiguous settings, here described as across teams.

> *"Coming from a hospital background, if I was involved in a client's case, I'd be pretty much responsible for all the spectrum, you would be the main coordinator, now working outside the health authority or trust, the majority of responsibility would fall on social work, so whereas in the past I would have put a whole package of care together for clients including social needs, now my work is very much to do with behavioral issues which are bound to include or reflect social needs, and we will do the work to set up the social needs' network, but the actual management and budget issues are passed firmly back to social services. Which is good you don't get bogged down and they should be better skilled to provide that service" (Rn2).*

Rn2: The example above incorporates knowledge of the shift in the context of practice, that is environmentally from the hospital to community, and organisationally from health to social care. Information in relation to individual professional responsibility and boundaries in terms of resources is also given. The participants' knowledge of context includes an understanding of both the social work and RNLD professional roles. Evidence of skill in determining own contribution and that of other professionals is also present.

7.6.1.8 Antecedents and Consequences Of The Term Contextual Socialisation

In developing a set of antecedents and consequences of the concept, another form of clarification of the concept takes place (Jasper, 1994 p. 774). Antecedents are the set of elements of the concept, which must be in place before the development of contextual socialisation. Here the practitioner has knowledge of the context based on ideological, environmental, economic and political awareness. Additionally they are able to see beyond their single professional margins to identify the skills and knowledge of other professionals. Their work takes them beyond narrow professional contexts to an interprofessional arena in which they are comfortable practising. These meanings form the antecedents for the term contextual socialisation. As this is a new concept, there are no previous meanings of the term to explore

and refine, although meanings of context and socialisation have been used to develop the interpretation of contextual socialisation.

7.6.1.9 Antecedents Of The Term Contextual Socialisation

The following antecedents need to exist prior to the use of the term Contextual

Socialisation:Knowledge of physical location

Recognition that context may restrain resources

Awareness of agency barriers and their impact

Political climate and its influence

Power of professional values

7.6.1.10 Consequences Of Using the Concept Contextual Socialisation

The consequences of being contextually socialised relate to outcomes for the person and other professionals. For example the consequences of being contextually socialised are:

Ability to determine factors influencing interprofessional relationships

Understanding of the clients potential for dis-empowerment

7.6.1.11 The Definition of Contextual Socialisation as used in this framework

Participants personal theory in relation to balancing political, economic, organisational, client focused and professional goals, to gain outcomes for service users, suggests an acceptance of and security with their role. They appear socialised into a practice environment which has few certainties, a need for sophisticated relationship building skills, a critical understanding of the role of other professionals, an adaptability of the role based on the particular context of practice and the power to practice to ambiguous boundaries.

7.7 Concept Two: Knowledge Of The Person with Learning Disabilities

7.7.1 The Person with Learning Disabilities

The needs of the person with learning disability are one of the stated primary rationales for action in the interprofessional team, across many of the categories in the descriptive analysis. When work is viewed as complex or problematic, the desire to reach an outcome of benefit to the client or service user is the driver for change. Categories CL: *Client,* K: *Claim to practice*,

and MC: *Client group as motivator* describe this in participants terms. Collectively these lead to an interprofessional role with the following practice characteristics:

7.7.1.1 Practice Characteristics

- Ensuring the persons needs are addressed by the interprofessional team.
- Pro -active practice which means making sure the best person to support the person takes action, this may be an advocate or a professional.
- Developing practice at service and organisational level not only at individual client level
- Being prepared to act in the face of unacceptable practice and despite unfamiliar circumstances.
- Working with clients, and other professionals to design effective models of care.

These characteristics are founded on the practitioner accessing a body of knowledge of people with learning disabilities, from a range of sources. Knowledge is defined in the Oxford Shorter Dictionary (1973) as awareness or familiarity gained by experience of a person, fact or thing Roget's Thesaurus (Kirkpatrick, 2000) offers knowing, cognition, and cognizance as synonymous terms. Websters Dictionary (1976) offers "the fact or condition of knowing something with a considerable degree of familiarity gained through experience or by contact or association with the individual or thing to know".

Within the traditional professions, knowledge is founded upon a three fold division; an underlying discipline or basic science component, an applied science or engineering component, and a skill or attitudinal component (Schein, 1974) Friedson (1986, p. 225) writes that a professions boundaries are determined by a body of knowledge used to solve problems within some professions area of expertise. This knowledge is specialised knowledge and is developed and sustained in institutions of higher education and divided into disciplines. Increasingly, the nature of knowledge has been the focus of debate in health and social care, and some of the key areas of research have focussed upon Professional Knowledge, Fook, Ryan and Hawkins (1997), Grant and Marsden (1988) O' Neill (2000), Conway (1998), and Carper (1978), and Knowledge and Expertise (Jasper, 1994), Benner and Tanner (1987), Polyani (1962) Dreyfus and Dreyfus 1977).

Additionally there has been some exploration of knowledge and its' relationship to the

care of vulnerable people in society notably Sines (1995) and Lee (1990) in relation to people with learning disability, and Tapp (2000) in relation to stigma and professional gaze.

7.7.1.2 The RNLD As Expert In This Study

However, is this form of expert knowledge and the use of the term 'expert' valid to describe the RNLD group in this study? When specialist knowledge, expertise and experience are discussed with reference to people with learning disability, it is likely to include and value local knowledge held by the person concerned and their family and unknown to the nurse, as well as other nursing knowledge. For as Tapp notes, (2000, p. 88) this is a significant element of expert knowledge. Jasper uses the process of identifying antecedents and consequences of the concept to further refine its attributes. The attributes need to exist before the development of expertise (Jasper, 1994, p.774). The antecedents of expert are highlighted as; 1) Having confidence in oneself and one's decision making skills, 2) Working with colleagues, 3) Exposure to a single environment in which skills and knowledge can develop 4) Holding appropriate basic qualifications in the chosen area and the opportunity to develop these. The consequences of becoming an expert are; 1) Accordance of high status within the profession 2) Consultation by others 3) Use as a role model (Jasper 1994, p.774). Evidence of all of the RNLDs holding all of the antecedents are present in the study (see chapter 6) and in the framework concepts (see above). Despite this, the consequential attributes are less conclusive. There is direct reference in the data to consultation by other professionals and to their position as a role model, but the status of the RNLD group remains limited within the profession of nursing generally and nationally in social policy, which is explored at local level in the descriptive analysis in chapter six. Further the views of service users in relation to the quality of knowledge held by RNLDs has yet to be formally recorded.

7.7.1.3 The Concept Knowledge of People with Learning Disability

Therefore although knowledge held by the practitioners in this study could be described as expert in relation to knowledge of people with learning disability, the concept expert cannot form one of the elements of the conceptual frameworks. Instead the concept " knowledge of people with learning disability" will be used. The inclusion of "knowledge of" has two meanings; firstly the need for specialist formal and personal theory from the RNLD in the interprofessional arena, as well as the equally important "Knowledge of" people with learning disability which ensures that the individuals' understanding of their situation is also at the core of practice.

7.7.1.4 Attributes Of The Concept Knowledge of People with Learning Disability

The attributes of "knowledge of" are; firstly the need for specialist formal and personal theory from the RNLD in the interprofessional arena, as well as the equally important "Knowledge of" people with learning disability which ensures that the individuals' understanding of their situation is also at the core of practice.

7.7.1.5 Case Examples of the Concept "Knowledge of People with Learning Disability"

> *"Once someone is with us, we find that we are taking a lead on input, and they are actually inviting us to come along with various propositions, and we will find that they will either go along with that, or we will have to argue a case. There are occasions when we may be under pressure to admit someone, because theoretically we have a vacant bed. I have been involved in this and I have to make a case to service managers, in the absence of other team managers based on gender or need rather than an apparently available bed." (Rn 8)*

Rn 8: The statement above describes the process of questioning a particular approach to practice, and the establishing of solutions to create change. Referral to the use of applied knowledge to develop good practice is present in the use of "There are occasions when we may be under pressure to admit someone, because theoretically we have a vacant bed. I have been involved in this and I have to make a case to service managers, in the absence of other team managers based on gender or need rather than an apparently available bed."

"With the Occupational therapist we work towards getting better equipment for people for example a part for a wheelchair, a piece for a bed. The OT knows which is the best bed for someones' posture same goes for the dietician, they know the nutritional needs for a specific person and we can actually make a compromise between clinical need and philosophical need without much hardship. They give advice and record it in notes and care plans" (Rn 3).

Rn3: Here in the above paragraph there is an example of the focus of interprofessional collaboration to meet need. Equally there is a description of applying knowledge in the phrase "We can make a compromise between a clinical need and a philosophical need." Applied knowledge is also used to determine the role of other professionals and the type of input they might have.

"If the service user woke up in the morning and did not want to keep his two or three appointments for that day, that was his prerogative. My role would be to phone these people or facilitate him phoning them, it might also include his parents because the family dynamics are also very much a part of the picture with me acting as his intermediary, and passing on his wishes to those people and it was felt necessary to get all those people together in one room, to make clear that we were going to respect those wishes. The work is ongoing, there are still things to sort out, but it is sorted out by and large." (Rn7)

Rn 7: This paragraph illustrates the practitioners' recognition of the place of the individuals knowledge. Reference to the person with learning disabilities prerogative and the passing on of his wishes show a recognition of this other form of knowledge. Equally the practitioner demonstrates applied knowledge in the facilitator or intermediary role described, where communication and advocacy skills are drawn upon to ensure the persons wishes are respected. Responsiveness and flexibility are demonstrated in the practitioners support of the individuals decision making processes.

7.7.1.6 Antecedents of the Concept Knowledge of People with Learning Disability

Acknowledgment of more than a professional response to meeting need

An underlying knowledge of People with Learning Disability is significant to develop good practice

Developing relationships with People who have Learning Disability

Questioning service interventions and taking action to create change

Focusing interprofessional collaboration on the needs of People with Learning Disability

7.7.1.7 Consequences of the use of the Concept Knowledge of People with Learning

Use as key source of knowledge by other professionals

Application of informal and formal knowledge of learning disability in interprofessional teamwork

Critical examination of relationships with service users.

7.7.1.8 The Concept Knowledge of People with Learning Disability as used in this Framework

The concept incorporates the ownership of formal and informal knowledge of People with Learning Disability. This knowledge is not context bound but fluid, with an active concern for taking forward the personal (service user held) and professional knowledge to create change. It incorporates known theory and practice in relation to meeting need together with receptivity and reflexivity in response to alternative visions of need. In doing so preventing the objectification of People with Learning Disability.

7.8 Concept Three: Empowerment

7.8.1 Empowerment and Practice

Practitioners in the research study are overwhelming positive about their contribution to practice in the field of learning disabilities. Nevertheless, in describing their position in the interprofessional team they do not shy away from their potentially marginalised status as a result of previous or recent social policy or legislation. Participants engagement in current interprofessional practice, and their capacity to influence practice outcomes, has led them to reappraise the nature of power and it's use in practice development.

7.8.1.1 Practice Characteristics

Here the research Categories Z: *Negative Experiences,* DE: *Professional Devaluation,* E: *Professional Empowerment* brings together a further set of characteristics, with attention paid to:

- The possibility of professional marginalisation created by a perceived lack of understanding of the role of the RNLD in practice.
- Changing own practice to meet contextual shift and subsequent client need
- The use of expert knowledge to endorse practice and personal contribution of others, not undermine it.
- Awareness of power and powerlessness being at the foreground of practice for the client and the practitioner.
- High levels of self confidence in the interprofessional arena.

These elements seem to be congruent elements of the concept of working with power or empowerment. However as empowerment has been described as a contested concept, further exploration of its' meaning is required here, before it can be added to the framework. Rappaport (1984, p.2) describes the idea of empowerment, wherein the idea is more important than the thing itself. In explanation, he suggests that we do not know what empowerment is, but as in obscenity we know it when we see it (Rappaport, 1984, p.2). Further there are imperfect but useful interpretations of it. Likewise in research studies, investigating peoples attempts to solve problems related to powerlessness and learned helplessness, solutions may be different, and findings may be contradictory and dependent on the time, place and context.

7.8.1.2 The Meaning of Empowerment

The Shorter Oxford English Dictionary (1973) defines empower as: To invest legally or formally with power to authorise, license. Also as "To input power to do something, to enable, to permit. Empowerment is defined as the action of empowering, the state of being empowered. Websters Dictionary, (1976) defines empower as "to give authority to, to delegate legal power to, to give facilities or abilities to." Roget's Thesaurus (Kirkpatrick, 2000) offer the following synonyms for empower: enable, endow, authorise, endow with power, invest with power, put teeth into.

7.8.1.3 Origins of the Term

The origins of the expression are in community work (Skelton, 1994, p. 415) and Ward and Mullender (1991, p. 21) define empowerment as broadly associated at one end of a continuum, with welfare consumerism at one end, and at the other with a service user movement which seeks a voice and to control services and themselves. Rappaport, (1994) describes empowerment at community level as people uniting to achieve common goals, whilst in social work practice empowerment has become a stated aim of assessment since the 1990s (Smale, Tuscan, Biehal and Marsh, 1993, p. 7). Braye and Preston-Shoot (1995, p. 48) offer the following definition of empowerment (Cited in Shardlow 1998, p. 31):

"Extending ones own ability to take decisions, groups or communities taking control of their circumstances and achieving their own goals, thereby being able to work towards maximising the quality of their lives, "enabling people who are disempowered to have more control of their lives, to have a greater voice in institutions, service and situations which affect them, and to exercise power over someone else rather than being simply the recipients of exercised power; " helping people to regain their own power (Braye and Preston-Shoot, 1995, p. 48).

There has been a growth in the use of the term empowerment as a key aim for professionals in health and social care in both practice led, organisational and managerial initiatives, resulting from reference to the term in political manifestos, health and social care policy documents and guidelines for practice in the delivery of human services.

In the field of nursing there has been considerable debate about the empowering role of nursing professionals, whilst in health promotion the education of clients has been viewed as significant on the route to empowerment (Tones, 1991). In learning disability practice, empowerment has featured as a significant aim of policy makers, professionals and service user groups in the last two decades. In the organisational sciences, empowerment is linked to leadership, where emphasis on delegated or shared power increases motivation, Conger and Kanungo (1988, p. 471) define empowerment as empowering interventions to enable workers to perform their work more competently. This definition is developed by Thomas and Velthouse (1990, p.667) to mean "changes in cognitive variables which determine motivation in workers." Thus, empowerment has a range of meanings eliciting action from the structural through to the individual level.

Kieffer (1984, p. 9) records the more frequent appearance of the notion of empowerment in discussion of preventive social and community intervention. Gilbert (1995, p. 865) notes that

from 1985- 1995, 378 papers related to nursing and empowerment had been published, whilst Kuokkanen and Leino Kilpi (2000, p.235) account for 395 from the database CINAHL and 518 from the data base MEDLINE between 1980 and 1998. and related to healthcare and empowerment. In the literature from the discipline of nursing, there has also been a debate about the environment and empowerment with attention to the validity of the concept in the hospital versus community setting.

For this research, themes explored have included difficulties in conceptualisation of the term empowerment (Ward and Mullender, 1991; Wuest and Stern, 1991; Skelton, 1994; Strauss, 1984) and empowerment in the teamwork setting, including the research of Engel (1994), Evers et al (1994) and Mitchell (1998).

7.8.1.4 The Meaning of Power

Both Gilbert (1995), Kuokkanen and Leino Kilpi (2000) and Reason (1996, p. 238) suggest that in order to understand the meaning of empowerment, there is a need to explore the concept of power whilst Loxley (1997, p. 51) focuses on the concept of power and its impact on interprofessional work and the meeting of need.

The Shorter Oxford Dictionary (1973) offers a number of definitions or uses of the concept power. These centre upon power as a quality or property. Firstly, the ability to do something or anything or to act upon a person or thing, secondly a particular faculty of body and mind. Power is described as put forth in various directions or on various occasions, including the ability to act, or affect something strongly, physical or mental strength, vigor, energy, force of character. Websters Dictionary (Webster 1976) defines power as: a position of ascendency, ability to compel obedience, control, domination, capable of acting or producing an effect. Roget's Thesaurus (Kirkpatrick,2000) includes the following synonyms for power, mightiness, greatness, pre-potency, prevalence, predominance, superiority, authority, control, sway. There is also a link with forms of power held, like governance, moral power, ascendency, influence, spiritual power, whilst the expression of power is defined through synonyms such as might, potency, energy, and vigorousness, drive force, oomph, get up and go, eloquency, fluency, and articulacy. Power has both positive and negative attributes, in the literature of health and social care focusing on three areas: critical social theory, and the oppression of particular groups of professionals and service users, organisational theory, with emphasis on the delegation of power and leadership to the individual level, and social psychology again with concern for the individuals connection and interaction with the environment (Kuokkanen and Leino-Kilpi,

2000, p.236). In nursing, power is often viewed as a negative concept, whilst alternative approaches to power have also been a key feature in the literature of power and empowerment, for example in the research of Lukes (1974), French and Raven (1959), Foucault (1980 and 1984), Gilbert (1995), and Sparrow (1997).

7.8.1.5 Empowerment as a Concept in the Framework

In relation to the framework presented here, the interprofessional teamwork setting presents an additional layer of complexity when empowerment is explored. Foucault offers methodological precautions that assist both in the practitioners' critical reflection of power, and in engagement with practice activity that may be empowering for themselves and others. Additionally a further set of knowledge and skills are necessary for empowering practice. These cannot be viewed as separate elements or interpretations of the concept, but are an integrated part of the overall meaning. However because of their significance as practitioner characteristics, and their applicability in interprofessional practice, they are discussed separately. These are:

- The use of knowledge to endorse practice and personal contribution of others, not undermine it.
- High levels of self confidence in the interprofessional arena.

Both of the above characteristics are present in all of the framework characteristics. They are integral elements of the concept empowerment and encompass some of the components of the organisational business models of empowerment.

Here they are significant because of their potential impact in the interprofessional work setting. In the research literature, tackling the disempowerment of practioners is explored from the individual perspective by Thomas and Velthouse (1990), Conger and Kanungo (1988) Kanter (1977), and Backer (1994) and from the group setting perspective by Reason (1996).

The practitioners in this current study have a critical understanding of the uncertainty of some of the likely contexts of practice, together with the ability to challenge without hostility, the performances of other professionals, and the failure of some service interventions. This has not affected their motivation to work towards change, for service users, themselves or other professionals. Thus, depicting characteristics of empowerment not cynicism. Thomas and Velthouse' s (1990, p.675) model begins to offer an explanation for this response. Equally as

organisational goals may be contradictory, and in conflict with service user or interprofessional goals, independent self confident, autonomous, practice may be viewed as a better indicator of empowerment, despite it not always having perfect results. Backer et al's (1994) nursing study found that bureaucratic organisation, control and task orientated nursing prevented empowerment.

7.8.1.6 Conceptual Congruence

Empowerment is described as a contested concept, with a range of interpretations of meaning being offered. Here the meaning given to the concept empowerment retains some aspects of the concepts use in other conceptual frameworks. For whilst the concept empowerment remains abstract and contested in the literature, a specific meaning has been conveyed in this research. The participants' management of the impact of power, both personally, in relationships with clients and professionally has driven discussion in relation to the adequacy and application of the concept here. What is significant is the mechanism of empowerment, which for the professionals here has led to the practical power to change their own lives, consistent with the idea of empowerment and without controlling others (Rappaport (1984, p. 3).

7.8.1.7 Empowerment: Defining Attributes

- When practitioners are empowered, they hold the following attributes:
- Knowledge of the interprofessional practice context and confidence within it.
- Familiarity with uncertainty and the imperfect nature of agencies.
- Skill in working beyond boundaries to support individual service users.
- Developing informal theories of interprofessional work to challenge and support interventions.
- Awareness of the negative as well as positive impact of power and its use.

7.8.1.8 Case examples of the Concept "Empowerment"

Examples from the data illustrate the defining attributes of the proposed concept.

"Crisis can dash high expectations of working relationships, and you have to go away and think about how you are going to realise those expectations, or lets put all those hopes and aspirations on one side and forget about it, it does happen with folk and you have to refigure out what the big bad world looks like, so it can be a part of your practice. You expect social services to take accountability and be supported by senior managers, when the reality is budget and numbers, and this does lead to uncertainty in professional roles." (Rn4)

Rn4: This example shows an understanding of the uncertainty of some of the likely contexts of practice, together with an example of the ability to challenge without hostility, the

performances of other professionals, and the failure of some service interventions. There is an acceptance of imperfect results for individuals, however this is not set in cynicism, it is offered within a strategy for re-thinking the intervention.

"My understanding about people and how they behave is based on developing my own communication skills, and it is about relationship skills and showing and actually demonstrating to people that you are willing to be open, that you are not going to be precious or defensive, that you are going to share your knowledge and not shroud it in mystery which some people would like to do, and maybe the organization might encourage. Yes actually demonstrating to people that you are going to be working together within the service. We have started writing out service intervention agreements which we are agreeing with people, (Service users) and then circulating to other people that are involved in commissioning so that it is sharing rather than keeping it hidden, " (Rn5).

Rn 5: Here an example of understanding the contradictory nature of organisational goals is presented along with individual strategies for dealing with the ambiguity created. There is understanding of the way power is used by the organisation to create distance between different professionals, and is in conflict with service user or interprofessional goals. The use of openness is a strategy to share power across professionals and with service users.

"We would be trying to help people with needs across health and social care, we have occasions where people from social care may feel that we are intruding into areas that aren't ours, and people make it clear that they aren't ecstatic about the prospect, but we will do it anyway." (Rn2)

Rn2: In this example, there is an understanding of the tension between need and service delivery in relation to health and social care. Additionally there is motivation to cross boundaries in order to meet need, and despite others being hostile a commitment to do so in order to support people with learning disability.

*" I look to learning disabilities nursing to achieve and create change. Its more powerful, it's not more powerful in terms of policy recommendations, but if you are into the job, not the big cheese, and come into this (*RNLD practice*) to actually help folk and create individual*

changes, then stick with nursing." (Rn2)

Rn2: In the above example there is knowledge of policy and the place of the RNLD. Additionally there is a recognition of the nature of power and its' use. Once again the contradictory and ambiguous practice agenda is addressed, along with a belief or motivation that change can be created by the individual practitioner and can impact on peoples' lives.

"Yes the way I would sum it up straight off the top of my head - a firm philosophy eg SRV and the seven service accomplishments, comes first, then empowerment, a real issue not as a buzz word which is all about giving people self awareness, the skills and the motivation for themselves, power should be equal, across professionals and clients in a team. A firm philosophical base to improve the lives of people and I think that is it also taking care of any service need, medical need, and physical health need" (Rn3)

Rn3: Here the practitioner acknowledges the rhetorical nature of the term empowerment along with demonstrating an understanding of its meaning. Power is seen as an issue for all professionals, and service users, with an underlying questioning of its' current place, for example as a buzz word.

7.8.1.9 Antecedents and Consequences of the Term " Empowerment"

The practitioner has a knowledge and understanding of the way in which power is used at policy, organisational and individual level. Strategies to work with and through potentially powerless positions are described. The presence of the motivation to create change also reflects empowering characteristics. These understandings form the antecedents for the term empowerment. There are multiple meanings of the term in use, therefore the process of refining and defining the concept here is intended to further demonstrate its application.

7.8.1.10 Antecedents of the Term Empowerment

Recognition of conflict of interest of professionals and service users

Seeking source of power in teamwork processes

Engagement in practice to challenge the balance of power

Questioning own motives in relation to sharing or owning power

Acceptance of imperfect outcomes in relation to power sharing

Acknowledging the source of difference openly

7.8.1.11 Consequences of the Term Empowerment

Critical Examination of own interprofessional action

Challenge other professionals without hostility

Professionals and clients will be aware of practitioners' position or view.

7.8.1.12 The Concept Empowerment as used in this Framework

Empowerment is used in this framework to describe practitioner thinking and action in working with power. The interpretation recognises the imperfect outcome of some interventions for individual people with learning disability and professionals. There is an engagement with the dynamics of power and an ongoing concern with the practitioners' own motives for intervention. Explicit acknowledgement of the organisations dual purpose as facilitator of change and rationalisation of resources is present, set within the national policy context.

From this position of understanding, empowerment stands for an energised approach to change without hostility or cynicism.

7.9 Concept Four: Transforming Capability

7.9.1 Practice Roles

Practitioners' descriptions of their own role, acknowledge the applicability of their knowledge, skills and experience (presence) to function within the arena. The Categories K: *Claim to Practice,* D: *Professional Recognition,* Q: *Questioning Practice,* R: *Contemporary Role,* X: *Skills and Knowledge gained,* W: *Skills and Knowledge* gained, and W: *Develop a position* all contribute to this professional confidence.

7.9.1.1 Practice Characteristics

This confidence is illustrated through the following practice characteristics:

- Building relationships and networks that are centred upon creating change for the service user and the team
- Actively engaging with the complexities of health and social care needs of people with learning disabilities.
- Motivation to confront the status quo in order to move service delivery forward, and achieve

results for individuals.

- Practice intervention, based on clarity and tacit knowledge.
- Documented experience of otherness, which has resulted in professional self awareness and assertiveness.

7.9.1.2 The Meaning of Transforming

This highly developed confidence appears in a practitioner who is able to use knowledge and skills to transform the opportunities of people with learning disability. The characteristic Transforming suggests the ability to make a thorough or dramatic change in the form, outward appearance or character of (Shorter Oxford Dictionary 1973). Websters Dictionary (1976) defines Transform as to change completely or essentially in composition or structure Transformative is defined as "having the faculty of transforming" or "fitted or tending to transform" (Shorter Oxford Dictionary, 1973). In Roget's Thesaurus (Kirkpatrick, 2000), the synonyms listed for transforming include modify, alter, vary, modulate, diversify, shift the scene and transform.

Websters Dictionary (1976) defines Transform as to change completely or essentially in composition or structure. Whilst Roget's Thesaurus includes the following synonyms: revolutionise, subvert, overturn, influence, capability, power, potency and potentiality (Kirkpatrick, 2000). In the literature of organisational management, Bate (1994, p. 81) describes a transforming strategy as "a radical basic second order change" and transformation by Levy and Merry (1986, p. 11) to define a response to a condition in which an organisation cannot continue functioning anymore. Transformed (Brown, 1994, Kanter, 1989 Handy, 1991) is used to describe six major features of organisations facing social, economic, political and behavioural change (Hackett and Spurgeon 1998, p. 170). These are responsibility to a range of stakeholders with diverse interests, with a need to command their long-term commitment. The blurring of boundaries and the need for cooperation across boundaries and organisations themselves. Technological changes and their implications, along with the need to capture individual and collective views to achieve long term change. Finally the customer is king, so organisations must continue to develop new networks and practice competently (Hackett and Spurgeon, 1998, p. 171).Most commonly in the literature of organisational management, transforming has been used to describe a type of leadership style, that of transformational leadership (Burns, 1978) which has as been explored predominantly in relation to the need for cultural change in institutionalised systems of care (Bowles and Bowles, 2000; Bass, 1995;

Posner and Kouzas, 1988; Hackett and Spurgeon, 1998).

7.9.1.3 Power and Leadership

The issue of the use of power is important to transforming leaders, where notions of exploitation or payback are no longer seen to be an effective way of building relationships with other professionals. Alternatively transforming leaders work toward a basis of mutual, values based agreement about activity based on creating positive social change.

Anderson (1998 p.108) offers a taxonomy of transforming practices, which includes the knowledge and skills required to transform people and organisations. These are presented as communicator, counsellor and consultant all underpinned by awareness and self management. What Anderson does not explore however is how individuals choose transforming practice as opposed to any other style of leadership which has been attended to in the work of Trofino (1993), Sofarreli and Brown (1998) and Posner and Kouzes (1988).

When it comes to interprofessional practice and its context, transforming styles of personal leadership may be seen as the most appropriate, but has yet to be explored in the literature. Ultimately, however charismatic a professional is, gaining credibility involves a demonstrable long term commitment to a particular course of action, in this case, bringing about positive change for the client group. Hence the need to both transform practise and be capable in practise, resulting in the next component of the framework, capability.

7.9.1.4 The Meaning of Capable

The Shorter Oxford Dictionary (1973) defines capable as gifted, able and competent, whilst capable of is the ability, fitness or necessary quality for. In Websters Dictionary (1976) capable is defined as able to take in, conceive or accomodate and having the quality of being able to perceive or accomodate. Capability is defined as an ability or power which may be an underused faculty (Shorter Oxford, 1973). In its common use, the meaning may be viewed negatively or judgementally as in 'having the capability', on an educational report. Alternatively the meaning of 'capable' is linked with other characteristics, which whilst positive may be intangible. Gifted may be difficult to measure although it could be used interchangeably with the "something special" criterion of the expert practitioner in nursing (Jasper 1994, p: 771). Able is defined in the dictionary (Shorter Oxford, 1973) as being clever and skilful, whilst "Very skilled in what they do " forms a criterion for a definition of expert, in Jasper's discussion of the concept expert (Jasper, 1994, p.771).

Competent has a range of meanings. Glen (1998, p. 39) explores this notion of competence in nursing, suggesting that to act competently is to demonstrate the ability to realise the values, the goals and other responsibilities that are necessary for good practice. Through the carrying out of these abilities a demarcation between the competent practitioner and the rest is drawn (Glen, 1998, p. 39). However other writers are more critical, defining competent as avoidance of a definite fault (Brandon and Davies, 1979). This might not matter if some services could be received quicker or more cheaply, but becomes more problematic in health and social care, where people have complex needs and when as Eraut (1998, p. 129) notes a job has multiple roles. In the literature competence has received attention in relation to its political meaning by Abels and Abels (1979), Eraut (1998), Clark (1995), and Bradshaw (2000). Significantly competence and capable have been the focus of debate by Eraut (1998 p 134) where competence is socially constructed and job referenced, whilst capability is individually stated and profession referenced. In any role Eraut, suggests it is likely that a person will have additional capability , that is what a person can do , but is not needed in the job as it is currently created. Likewise in a new job, there are often areas of the role, which is outside their area of capability, as they will need to learn about contexts of practice (Eraut 1998, p. 136). Eraut sees this interaction between the person, their professional work and the changing demands of practice as a critical factor in determining the success of the organisation

and the quality of care to clients. He continues to explore the links between competence and capability. Firstly current competence is part of a person's capability and competence is usually inferred by job performance. Secondly the range of current competence is most easily extended when further learning can build on additional areas of capability. Significantly this must be recognised by employers and professionals involved. Finally, part of professional capability involves being able to transform individual practice, creating new knowledge and learning from others.

7.9.1.5 Transforming Capability: Defining Attributes

When it comes to interprofessional practice and its context, transforming styles of personal leadership may be seen as the most appropriate. Consequently defining attributes of the concept transforming are used here together with the term capability. The defining attributes of capability encompass Erauts' definition, with competence being an element of it. Likewise it takes Glen's (1998, p. 40) interpretation of competence where nursing is art, and competence is viewed as pushing forward the boundaries of professional practice.

Glen notes that individuals may move from one view of nursing to another depending on the workplace preferences, and she explores this using Harre's (1983) thesis on personal being, and Kelly's (1955) ways of believing and operating. Here the term capability includes a definition of competence which has a creative element. For as Glen notes if a person learns by concentrating on nursing as craft or labour, they will be able to be productive, but they will not be able to work beyond a blue print (Glen, citing Kelly 1955). Practitioners working interprofessionally are continually working beyond the traditional role and to create change may need to do so.

In the framework, the defining attributes of transforming capability, take into account both the potential for knowledge and skill development, together with the capacity for creative leadership in practice. At the same time it acknowledges the constraints that employers or organisations may put in place and the need for independent thinking, based on critical reflection of practice to work beyond or with such constraints. Because of the documented experience of otherness by the research participants, and the newly emerging areas of interprofessional practice, the inclusion of the concept competence would have excluded the potential and creative capability that is present.

7.9.1.6 Case Examples of the Concept Transforming Capability

Examples from the data analysis illustrate the defining attributes of the proposed concept:

"There tended to be a duplication of effort for that person, and for that service user, we became part of the problem. It meant sitting down and saying who exactly are we talking to and why? It might as a result of a multi disciplinary meeting, mean that certain aspects of care take a back seat. Another example having first done an initial assessment, we have been able to find an independent advocate, so a lot of the work I would have covered, I am now happy to let go of because I feel it is more appropriate for an advocate to work directly with the service user. So no relationships are static, and because someone has been with us for six months, their needs may change dramatically, the dynamics of various professional relationships change constantly in that six months, and we would try and evaluate what is happening and make sure changes are made to continue to meet the person's needs." (Rn7)

Rn 7: The example above includes examples of creative leadership, where reflection is used to highlight blocked areas, for example becoming part of the problem. A refocusing on the issues in the form of questioning 'who' we are talking to, also suggests a motivation to learn or change. The statement 'no relationships are static' implies room for new thinking and evaluation of practice. An acknowledgment of constraints is referred to in relation to duplication of effort and the dynamics of various professionals. The data as a whole is reflective in style and suggests creative capability .

"I think there are valuable lessons to be learned in terms of team-working, so I guess my personal experience across disciplines can work and work very effectively. My training, obliged me to take a fresh look at my workloads and beliefs and whilst I kicked out at some of that at the time, and still don't agree with some aspects, at least it did force me to have a look and then I guess consolidating that into my practice over the last year or so, trying to take the good from both sides to the point at which I can work effectively and learn from people, even if I don't agree with where they are coming from, because at the end of the day, the driving force behind it, still remains for me the best interests of the service user, and in service development in general I guess," (Rn7)

Rn7:Once again there is a reflective style about the data which offers examples of creativity, for example learning from others, trying to take the good from both sides, acknowledging the

difficult constraints whilst seeking personal change. Motivation for change in terms of transforming attributes are illustrated through the service user focus. The experience of working in teams gives evidence of working beyond the traditional role, as does the term across disciplines.

7.9.1.7 Antecedents and Consequences of the Concept Transforming Capability

Here the practitioner has the knowledge to change practice interventions in the use of transforming leadership characteristics and creative practice roles. This approach forms the antecedents of using the concept "Transforming Capability". As this is a new concept there are no similar meanings to explore although the meanings of transforming and capability have been explored to develop the interpretation of transforming capability.

7.9.1.8 Antecedents of the term Transforming Capability

Extensive personal motivation

Challenging the accepted norm

Works at relationships with other professionals

Ability to learn new skills and develop informal and informal knowledge

Demonstrates new knowledge in a range of contexts

Independent thinking

7.9.1.9 Consequences of using the Concept Transforming Capability

The consequences of being viewed as having transforming capability are:

Responsive to changing demands of practice

Other professionals will seek collaboration

7.9.1.10 The Definition of Transforming Capability as used in this Framework

Participants ability to change practice by creative thinking and relationship building suggests that they are motivated practitioners. Equally they have the capacity to work beyond the narrow boundaries of the nursing role within the team, and are prepared to change in order to do so. Through this process they will continue to learn and develop, working with and through organisational constraints. The RNLDs in this study are equipped to lead in the interprofessional setting within a definition of leadership which takes into account, firstly the key differences in Burn's (1978) transactional and transformative leadership styles (Trofino 1993, p. 179).

Transactional leadership is usually based on a relationship with followers, based on a short-lived exchange of resources. In contrast transformative leaders have a different type of relationship with followers where there is a shared common purpose that can benefit the organisation. Burns (1978) highlights these leadership roles as being elevating, mobilising, inspiring, and exalting. Boulter and Cook (1997) and Moore (1999) advocate the RNLD as the ideal person for the transforming leadership style, for whereas traditional transactional leadership is usually intent on the completion of tasks, this may no longer be a valid model in the health or social care services of the future (McDaniel, 1997, p. 21). Transforming leaders seek to seize opportunities, create change and empower others (Kanter, 1983 p. 156) which fits with the leadership role outlined and evidenced in this conceptual framework. Further, Sofarelli and Brown, (1998, p.202) argue that such transformational leadership is less concerned with management of the short term and more about the holistic perspective (1998, p. 203). This means that in the interprofessional context other professionals are likely to identify the RNLD as the person with a more developed knowledge of the person with learning disability and thus seek their advice to create change.

7.10 Concept Five: Conflict Management

7.10.1 Conflict and practice

The practice characteristics identified, have in turn influenced and been influenced by, the conflict creating aspects of participants' interprofessional work. Participants adopt conflict management styles in the face of crisis in practice, and are not in denial of the existence of conflict.

7.10.1.1 Practice Characteristics

Categories VP: *Validating Practice,* C: *Crisis,* J: *Criticism* and T: *Communication* constitute examples of this:

- The need for a balanced or impartial view of other professionals in a crisis situation.
- Acknowledging the need for reflective learning in relation to own and others' views in crisis focused teamwork
- Acting autonomously to improve communication and create change.
- Staying with a problem to find a solution rather than withdrawing from the arena.

- Seeking and maintaining a dialogue with other professionals despite the difficulties this may present.

Participants describe their management of conflict in the practice setting. Working with conflict is a key element of practice activity, with participants accepting its presence. Weider Hatfield and Hatfield (1995, p. 687) suggest that in order to understand conflict management an awareness of the amount of conflict in an organisation, together with the styles of interpersonal conflict operationalised is needed. Here a range of conflict management attributes are identified, which have been conceptualised as Conflict Management. This concept is already present in the formal literature of health and social care, drawing on other disciplines such as organisational business and social psychology. The preliminary task, is to compare meanings and models in the formal literature for similarity and difference with the processes used and characteristics identified here. Following this a clarification of meaning and the level of conceptual congruence can be addressed.

7.10.1.2 The Meaning of Conflict

The Oxford Shorter Dictionary (1973) defines conflict as to fight or do battle with, to clash or be incompatible. Websters Dictionary (1976) offers the act of striking together, clash, competition or incompatible forces or qualities as ideas, interests or wills. Roget's Thesaurus (2000) presents contrariety, differ, disagreement, counteraction and opposition as synonymous terms. Other terms used in the literature have included conflict resolution, avoidance, avoidance, conflict of interest, interagency conflict and role conflict. Whilst there have been a number of definitions of the term, unlike the concept empowerment there has been a lack of debate as to its meaning.

In the literature exploring conflict, definitions have been founded on organisational and interpersonal dysfunction (Cavanagh, 1991, p. 1254). These have included the view of Pondy (1967) who sees conflict as a dynamic process "wherein the views of two or more individuals in an organisation can be analysed as a sequence of conflict episodes" (Pondy, 1967, p.296). Bernstein (1973, p. 72) who places conflict as a part of group processes whereby conflict "has its terrors, but it frequently offers magnificent opportunities for growth" Secemsky et al (1999, p. 37) who believe that "conflict is a concept that is mis understood and considered by both to be an undesirable state". Zalesnik (1997, p. 56) who suggests that "this complexity in human nature, especially our conflicting tendencies to co-operate and to

go it alone- leads managers to spend their time smoothing over conflict". Whilst Eisenhardt et al (1997, p. 43) note that " top management teams typically face situations with high ambiguity, high stakes and extreme uncertainty. Discord, contention, debate disagreement in short conflict are natural in such situations".

Rahim (1986) proposes six categories for sources of organisational conflict , affective conflict, conflict of interest, conflict of values, cognitive conflict, goal conflict and substantive conflict (Weider Hatfield and Hatfield, 1995, p.687). Intra-personal conflict occurs when a professional or worker is required to practice in away that do not match her values, expertise, or goals. Interpersonal conflict relates to a difference of opinion, approach, style between individual professionals or workers in an organisation. Cavanagh (1991, p. 1255) offers five basic conflict management styles, these are accomodating, avoidance, collaborative, competitive and compromising.

Another form of conflict explored in relation to health and social care, is that of role conflict defined as competing expectations of role responsibilities, functions and priority setting for carrying out functions (Hardy and Conway, 1988 , Pranulis et al, 1995). Role conflict is a problem that accumulates over time and can result in a number of physical and emotional conditions such as depression and emotional exhaustion. Likewise it is also responsible for professional dissatisfaction (Alexander et al, 1982). When particular elements of professional role and conflict have been explored, role conflict has been identified as a key source of emotional exhaustion for professionals (Barber and Iwai, 1996, p. 111), in contrast to role ambiguity which did not have the same effect. Role conflict was identified as being particularly prominent in more recently qualified professionals. Common themes in the literature have been whether conflict in practice should be seen as a good or a bad thing, (Thomas, 1976; Schallenberger, 1981; Rahim, 1983; Folger and Poole, 1984; Cosier and Dalton, 1990; Cavanagh, 1991; Wieder- Hatfield and Hatfield, 1995) and developed to an exploration of conflict management in groups (Unger, 1990; Secemsky, 1999). The relationship between conflict and collaboration has also received attention, Lowe and Herranen (1978) relate conflict to teamwork and Williams et al (1978) explore confusion and conflict. Hilton (1995, p. 34) explores the literature in relation to conflict in teamwork and includes the terms disconnectedness (Temkin -Greener, 1983) discrepancy (Hopper et al, 1987) and fragmentation (Leninger, 1972). Disconnectedness is described as the contradictory goals of professionals, discrepancy relates to actual and ideal interprofessional participation in care planning, and fragmentation as a result of isolationism and single professional

education. Most references to conflict describe potential causes, and can be linked to the literature of intergroup relations, centred on the nature of contact from Allport (1954).These are commonly the need for equal status, pursuing common goals, and organisational support, without which, conflict will be likely. Coser (1956 cited in Cavanagh, 1991, p. 1234) draws attention to the closeness of individual group members as a possible cause of the suppression of conflict. Coser suggests that in some situations the expression of hostility may be viewed as unacceptable along with a failure to acknowledge that conflict exists at all. Ross (1982) defines collaboration as the maximum use of both cooperation and assertion , and places collaboration, as other writers, in his framework of conflict management styles (Sawdon, 1990, p. 74). In many instances in the team work literature, collaboration is seen as the route to the removal of conflict yet this may not take into account a lack of understanding of the true meaning of the term by some professionals. Brown (1992, p.304) draws attention to the move away from collaboration as the answer to interdependence and diversity in the social sciences, noting as Loxley (1997, p.70) that this ignores the issue of limited resources and power difference which are also determinants of conflict. Thus the term collaboration may also be used in a rhetorical sense by policy makers and professionals alike.

7.10.1.3 Conflict Management and its Application in the Conceptual Framework

With the increasing use of the term collaboration in the literature of interprofessional practice, it may well have been proposed here, as a framework concept in its own right. However the characteristics identified by participants in this study, are broader than the definition of collaboration by Ross (1982) above, as they provide examples of all five of the conflict management styles identified by Cavanagh (1991). Hence the concept Conflict Management forms the fourth element of the conceptual framework. Acknowledging the use of a range of approaches to conflict recognises that firstly there is no right or wrong method for dealing with conflict, and as the participants in the study have demonstrated, it is the situation or context which will determine the approach taken. As Sawdon (1990, p. 75) notes, we may use a preferred style in the wrong place with adverse consequences, when the real aim should to have the skills to use any style according to our analysis of the situation. As highlighted by participants, ensuring communication channels are kept open is vital but equally not at the expense of a poor service. Gaining an understanding of why conflict is occurring is an important element of practice and without this knowledge, collaboration is not likely to be successful. Therefore making judgments about the appropriate response is crucial.

In the process of determining a conflict management style, practitioners cannot operate effectively without integrating the other framework concepts of contextual socialisation, transforming capability and empowerment. If the characteristics of these concepts are ignored in the decision making around conflict management styles, there is a danger of neutralising conflict leading to a maintenance of the existing status quo. As Humphries (1988, p. 8) notes this would reduce the potential for change and the sustaining of existing social structures. For example in determining the conflict management style to be used in a situation, the practitioner draws on her knowledge of the context of practice, including the people involved, their needs both previous, current and in the future, the environment both physical or social, and the availability of resources. In addition, an assessment of the need for change will be part of the process, using the practitioners transforming capability. Critical thinking in relation to the urgency of the need for change will underpin this.

Likewise the issue of power, with the practitioner questioning herself about the targets of power in the situation, who stands to gain or benefit from decisions made, how is power at least on the surface being directed, and how detailed is the practitioners' understanding of its source and use. Equally practitioner motivation for the use of power and the direction of action being channelled are also in need of exploration. These critical interprofessional reflections-on -action will help identify the key factors in determining the conflict management style adapted. Additionally the constant use of collaboration skills ie maximum assertion and cooperation may be appropriate but in some contexts may not always be the best timed response.

7.10.1.4 Defining Attributes: Conflict Management

Acknowledging the use of a range of approaches to conflict recognises that firstly there is no right or wrong method for dealing with conflict, as the situation or context will determine the approach taken. Ensuring communication channels are kept open is vital but equally not at the expense of poor quality service provision. Gaining an understanding of why conflict is occurring is an important element of practice and without this knowledge, collaboration is not likely to be successful. Therefore making judgments about the appropriate response is crucial. This involves knowledge of the context of practice, including the people (with learning disabilities) involved, their needs both previous, current and in the future, the environment both physical or social and the availability of resources.

7.10.1.5 Case Examples of the Concept Conflict Management

Case examples from the data illustrate the defining attributes of the concept in this framework.

"It is very much about trying to help other people see other perspectives other than a rigid health and social care divide, rather saying we are all here to meet the needs of an individual that exist somewhere on a continuum and maybe if we can have some sort of constructive working relationship A/B got to be better for that individual than wasting time looking for C. Some of the health professionals are really good to work with." (Rn8)

Rn 8: Here the participant endorses the need to work at sustaining communication channels, facilitating others to look more broadly at the issues that have caused crisis. In this example the participant uses a compromising style of conflict management involving cooperation, that is the 'trying to help others' descriptor, and assertion where a clear message about shifting things forward is made, illustrated here in the "A/B has got to be better for that individual than looking for C description". This phrase also includes a further commitment to staying in the crisis situation rather than using avoidance, along with the stated desire to maintain working relationships and the drive for a solution message.

" In the same way as you would use a different language to a social worker than in work with clients, it isn't helpful to be looking for scapegoats when things go wrong, but an honest discussion, maybe with some clearing of the air can only help in future collaboration with that person." (Rn6)

Rn 6: Once again a commitment to staying in the relationship with other professionals, and maintaining communication channels is very strong. The conflict management style adapted is collaborative, seeking to solve problems, and still maintain own position. The example given of an honest discussion implies clarity in terms of professional views and openness in expressing them. There is no evidence of conceding or shifting perspectives from the participant. "Clearing the air" suggests a reinforcement of the participants' position or view with the other professional involved. Equally the stated desire to avoid seeking scapegoats depicts a professional who wants to maintain communication and keep open ongoing channels of interaction.

"At the end of the day, it is because a placement may have been unsuccessful,

and you have either got to create change for that person, or you have to find a new placement for them. It means good team working with social services and making sure we all do it right or inevitably some other solution will be found, that meets nobodys needs." (Rn9)

Rn 9: This perspective on conflict acknowledges a compromising and collaborative conflict management style. The participant notes the need for sustaining good working relationships and taking the middle ground to seek a solution that indicates compromise. Additionally the strong desire to problem solve, in the phrase 'Making sure we all do it right', incorporates collaborative elements. Throughout the statement the commitment to maintaining relationships is validated in meeting need for people with learning disability.

7.10.1.6 Antecedents of the use of the Concept Conflict Management

Recognition that conflict is present in inter-professional practice
Acknowledging other professionals views without hostility
Working to keep communication channels open
Maintaining presence in crisis situations
Use of collaboration in interprofessional relationships as appropriate
Using reflection to determine conflict management style

7.10.1.7 Consequences of the use of the Concept Conflict Management

Works with conflict in interprofessional relationships
Repertoire of decision making skills in choice of conflict management style
Critical Evaluation of individual performance in crisis situation
Sustaining focus in crisis centred practice
Professionals will recognise commitment to seeking a solution to crisis.

7.10.1.8 The Concept Conflict Management as used in this Framework

From a position of informed critical thinking, the practitioner determines the conflict management style to be applied in the individual practice situation. Emphasis on maintaining links with other professionals and being transparent in terms of action and perspective underpin

the concept's application.

7.11 Concept Six: Interprofessional Reflection- in- Action

7.11.1 Reflection in Action

Evidence of commitment to the interprofessional arena and to team working underpin participants' practice. This commitment is founded on a well developed, largely informal knowledge base which operates from a position that is not idealised or reified. Practitioners are prepared to take risks, work within imperfect situations, and push professional boundaries if necessary to achieve outcomes that are of relevance to clients. They are constantly questioning their approach and response in the interprofessional practice situation.

7.11.1.1 Practice Characteristics

In this research, many of the categories illustrate examples of this. However from Category P : *Interprofessional Knowledge,* and A : *Affirming Interprofessional Practice* the following characteristics are significant:

- Interprofessional working can create a supportive environment for practice, whilst not shielding bad practice.
- Interprofessional practice prevents professional insularity, and offers new approaches to problem solving based on who is best skilled at meeting need.
- Interprofessional practice begins with facilitating a dialogue of communication between professionals, based on client issues.
- Interprofessional practice often involves working in unfamiliar situations or circumstances and finding new solutions to problems.
- Interprofessional practice may both clarify and blur professional responsibility and accountability.

These practice characteristics summarise participants expectations of their own and other professionals action in the interprofessional arena. The characteristics say as much about the processes informing interprofessional work as they do about defining the term interprofessional. These include the use of personal knowledge, development of informal theories and interaction with situations and outcomes related to interprofessional work. A

combination of which can be described as the concept interprofessional reflection - on- action.

7.11.1.2 A New Term and its Application

The concept interprofessional reflection-in-action remains unexplored in the literature. However separate elements of the term have received attention in the research and practice based literature of health and social care although not in the ordinary dictionary sources.

The term interprofessional is used in the literature to describe various professionals, carers and service users working and learning together (Leathard, 1994, p.5). A range of other labels are used, and Rawson (1994, p. 39) suggests that these include three sets of concepts:

- Those with problematic association: inter/ multi or trans professional (see chapter two),
- Groupings, for example: professional/ occupational/ disciplinary/sectoral/ agency,
- A focus on operations: work/ teamwork/ collaboration/ cooperation/ integration.

All are used interchangeably in the literature of health and social care with only the concept collaboration being explored comprehensively in the literature (Loxley, 1997). Rawson (1994, p. 40) prefers the term inter- as the prefix to professional as it implies both relationships between and among elements and also carries a notion of reciprocal operations. Leathard (1994, p. 6) draws on Latin, where 'inter' is translated to 'between'. Payne (2000, p. 9) writes that the prefix 'inter' does imply the adaptation of roles, knowledge skills and responsibilities to adjust to other professional groups or agencies. Carrier and Kendall (1995, p. 30) develop the definition to include a willingness to surrender work roles, share knowledge and integrate procedures on behalf of clients.

Equally professional is taken in a broader sense to include more than the professional roles defined by Etzioni (1969) limiting them to the clergy, medical doctors and lawyers (Rawson, 1994, p .40). Professional includes a wider group of people, and is described by Payne (2000, p. 9) as a concern for different professional groups and their functions and activities. Practice describes the repertoire of activity, or work of professionals, and is viewed in health and social care as centred on the person (client) and their family. This can be distinguished from the term practise which involves a repetition of processes.

The use of the term action implies immediacy of response in the practice context. Action involves doing, and has a sense of energy about the processes involved. In the health and social care professions the term is linked to change or problem solving, and may be as a result of crisis

intervention. Action may be used to describe the end result or service to the client based on knowledge, applied knowledge and communication. Schon (1983) suggests that the connection of knowledge and action moves away from the traditional positivist stance that separates "deciding from doing". Alternatively the practitioner working in a constantly changing practice context uses knowledge and skills that are not dependent on a set of pre-determined rules(Schon, 1983). Actions are described by Bartlett (1990) as intentional, and to be understood in the social context of their occurrence. When applied to practice these processes inform deliberation and analysis of ideas about 'nursing' as a form of action.

Carr and Kemmis (1986, p.200) introduce the concept of the action research model , based on four stages of reflection, planning, acting, observing, and reflecting. These offer practitioners the opportunity to organise themselves into collaborative groups for the purposes of their own enlightenment, creating a model for a democratic social order.

Action is most commonly used in the literature of health and social care with reference to Schons' reflection- on- action and reflection-in- action (1983) and this is developed by Fitzgerald (1994), and Rolfe (1997). In the educational setting Kolb and Fry (1975) have developed a learning cycle centred on reflection, whilst Boud et al (1985) has offered a three stage reflective process model. For nursing, Mezirow (1981) offers seven levels of reflectivity from consciousness in levels one to four, to critical consciousness at levels five to seven. Mezirow makes a clear distinction between reflection and critical reflection, with reflection exposing and assessing the assumptions that support our belief systems, and critical reflection going one step further in challenging the validity of these assumptions. Wing (1988, p. 14) suggests that the validity of reflections is challenged within a historical, social, cultural and political context.

7.11.1.4 Interprofessional Reflection-on-Action

During the interview process, participants were engaged in interprofessional reflection-on-action, in a critical exploration and review of their own personal theories and knowledge. These constructions are also vital in the practice setting, when change is ongoing and a formal theory of interprofessional practice in its very early stages. Equally the outcomes of interprofessional action may be perceived as ambiguous, being not immediately observable as in other areas of practice. For example gaining a referral for a person with learning disability, to a particular specialist in mental health may involve a series of complex interactions with other

professionals, and the client and their family, that draw on formal theories in relation to dual diagnosis and family work, and formal and informal theories of interprofessional practice. It may be some time before the outcome of the referral will be known, and during this period the context of care for the person may change. Likewise the criteria for referral may shift in response to pressure on funding, requiring constant attention, emphasising the need for reflection-on-action, as a means of interpreting options taken in decision making, and in constructing knowledge to inform future activity.

Thus the concept Interprofessional Reflection-on-Action forms the final concept of the framework.

7.11.1.5 Defining Attributes of the Concept "Interprofessional Reflection- on- Action"
A critical exploration and review of one's own personal theories and knowledge. Constant attention to practice intervention, interpreting options taken in decision making, and in constructing knowledge to inform future activity.

7.11.1.6 Case examples of the Concept"Interprofessional Reflection -on- Action"

"To gain a good working relationship, practice action is required. This may be a follow up action, or it may be a challenging action, that is not being afraid to have an exchange of thoughts with someone. If a person is closed up, so doesn't chase up what is happening, then what they are doing won't work, won't be so successful. " (Rn7)

Rn 7: This practitioner uses reflection on previous experience to drive forward interprofessional relationships. A concern with the result of different approaches in practice is present, here described as 'If a person is closed up, so doesn't chase up what is happening' and 'not being afraid to have an exchange of thoughts with someone'.

"Developing empathy and understanding I am not sure that this necessarily comes naturally, I think you have to think about it. I mean we all get cross with people and it may be the fifth time you have had to sort it out that week. Resolving a difficult situation, won't come from bringing anger about it, into that communication, and there isn't time to be angry with people. " (Rn 6)

Rn 6: Here the exploration of empathy is built upon reflection. A concern with thinking about developing understanding and how to respond in communication underpins the interprofessional response. The examination of previous experience also informs current thinking: for example 'Resolving a difficult situation won't come from bringing anger into it'.

7.11.1.7 Antecedents of the Concept "Interprofessional Reflection -on- Action"

Applies knowledge of context to develop interprofessional role

Uses previous experience of interprofessional teamwork to evaluate progress in problem solving

Questions professional and interprofessional accountability in seeking solutions and change

Recognises opportunities to create change based on previous experience

Acknowledges strengths and contribution in interprofessional teamwork

7.11.1.8 Consequences of the use of the Concept Interprofessional Reflection- on- Action

Expansion of interprofessional practice knowledge

Critical reflection on interprofessional practice action

Generation of personal informal practice theory

Confidence in interprofessional practice

7.11.1.9 The Concept Interprofessional practice-on-Action as used in the Framework

The ongoing critical thinking around interprofessional practice intervention underpins the concept in the framework. A concern with re-evaluation of professional knowledge and responses in the interprofessional arena is centred upon service user need and gaining the most effective outcomes from a practice situation. Taking responsibility for professional action and reflecting on its potential consequences for interprofessional team working plays an integral part.

7.12 Connecting Concepts : the Inter-relationship of Concepts within the Framework

7.12.1 Connecting Concepts : the inter-relationships of framework concepts

The focus of this framework is the facilitation of individual interprofessional practice in the field of learning disability (see figure 14). Concepts have evolved from an exploration of the

personal experience of practitioners. From this position the practitioner's knowledge of the context of practice and their awareness and familiarity in it, that is socialisation, together with their knowledge of people with learning disability precede all other concepts in the framework. However this knowledge is not static, as the iterative nature of the interprofessional- in- action concept, both drives and directs the development of new knowledge and influences new informal and informal theory.

Only when knowledge of the person with learning disability and contextual socialisation is present, can empowerment occur. In other words, without a clear understanding of the tensions of policy and its implementation at local level, or a detailed analysis of professional roles in the light of political or economic ideology, can barriers to change be identified. Only from this position can the practitioner work effectively in the identification of the sources of dis- empowerment.

Equally, knowledge of the person with learning disability involves formal theory: for example in relation to the likely outcomes of a particular medication for epilepsy, and informal knowledge in relation to knowing the individuals feelings about those outcomes. Without this knowledge of the person with learning disabilities, it would not be possible to plan practice action to identify the mechanisms for an empowering outcome. This understanding of the foundations of the relationship between the professional and the person with learning disabilities in this practice situation, is necessary for any real exchange or sharing of power to take place.

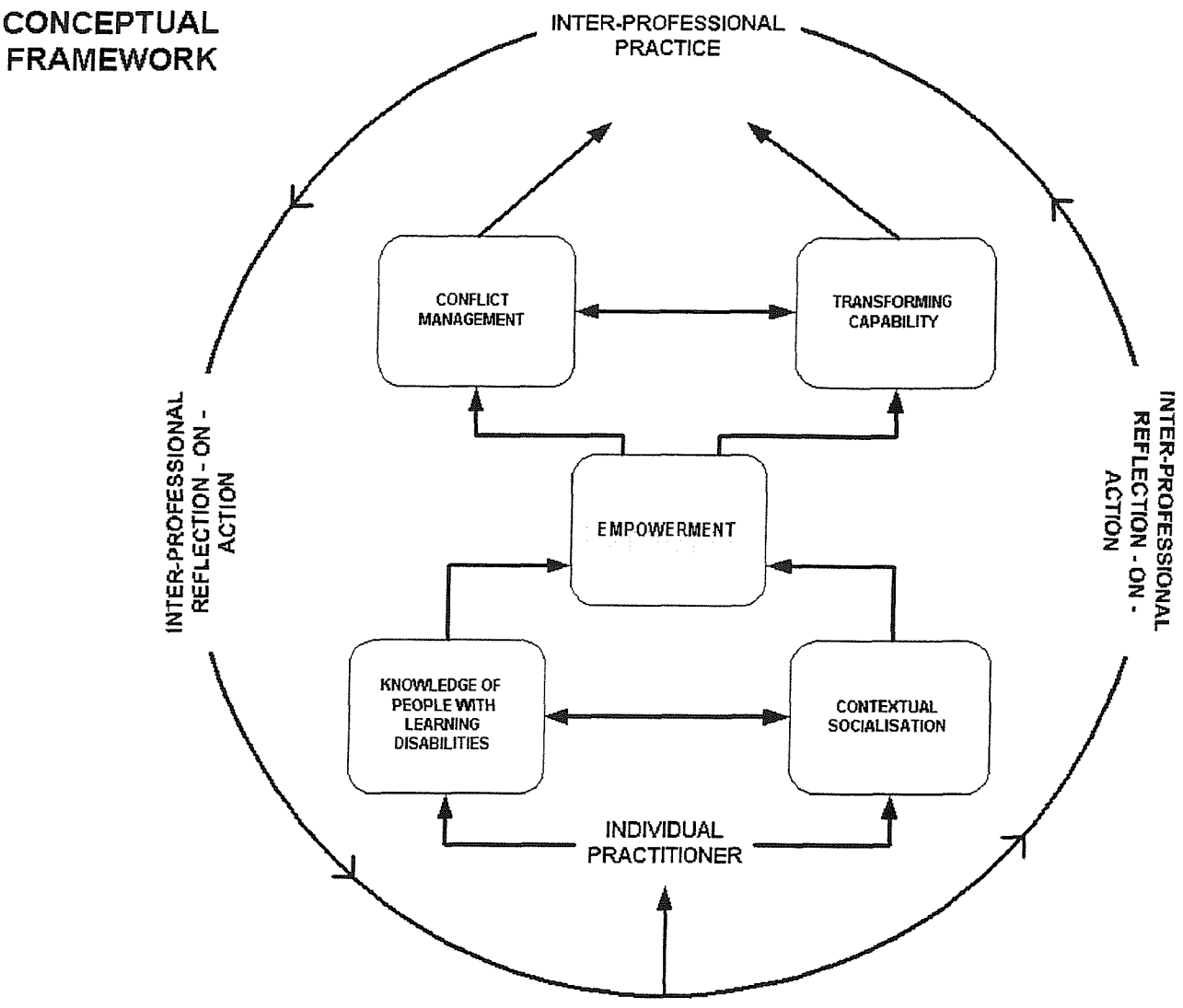

Figure 14. The Conceptual Framework

Once the characteristics of the concept empowerment are in place, a link with the concepts conflict management and transforming capability can be made. This inter-relatedness between empowerment and conflict management, and empowerment and transforming capability unites further the concept elements in order to address the role of power. This is because without a clear understanding of the nature of power in a particular interaction, the conflict management style may be destructive, and based on a personal desire for control. Further transforming capability is founded on shared power and mutuality and the potential for creative and participatory practice, as opposed to autocratic leadership based on oppression and the mis use of power to block rather than facilitate change.

The connectedness of these concepts enables responses to problem solving based on

need. It acknowledges the potential marginalisation of service users and some professionals. At the same time drawing on knowledge of context and of people with learning disabilities, to determine appropriate methods of support for others faced with the ambiguity created by interprofessional working.

Only when the practitioner holds the qualities of the concepts contextual socialisation, knowledge of people with learning disability, empowering practice, transforming capability and conflict management can they accomplish effective interprofessional practice.
Simultaneously the concept interprofessional reflection-in-action contributes to the continual refining and refocusing of that practice by drawing on the practitioners' experience of all the concepts in the framework.

All of the concepts are inter-connected, and must be present for effective practice to take place. For example whilst a practitioner may hold the qualities of knowledge of the person with learning disability and of transforming capability, they are unlikely to create real change without an understanding of the nature and role of power (empowerment concept) and their place in that interaction. Equally an absence of contextual socialisation would also lead to a failure to work through some of the reasons for dis-empowerment of people with learning disability, and in particular those in long term care who are at significantly at risk of being marginalised through policy tensions and gaps in service provision.

7.13 Towards a Conceptual Framework for Interprofessional Practice in the field of Learning Disability

In this chapter the process of concept development has led to the proto-type conceptual framework. Set in the long term support of people with learning disability, a field of practice with limited theoretical models for practitioners in place, and seeking to inform the generation of effective interprofessional practice within it, has presented a major challenge. Nevertheless the model has the potential to contribute to future practice and research in the field as well as informing educational curricula. Equally practitioners who use the model as a guiding tool for practice, may themselves become further empowered. At a time when many professional boundaries are uncertain, a practitioner who addresses the knowledge and action components of this model which acknowledges the ambiguity of the interprofessional role, may begin to re shape their professional responses.

No longer will professional action be centred on seeking certainty or a unique area of practice, as the practitioner will own a personal strategy for practice. Focused on striving for

change for people with learning disability, based on a clear understanding of their own use of power and with a well developed, independent understanding of the wider forces of power that are connected with it.

There are a number of issues in relation to the further refinement and application of the tool which still need to be addressed, and both the scope and possible uses of the framework will be explored in chapter eight.

Chapter Eight

The Framework in Practice

Chapter seven has outlined the development of a conceptual model generated to provide practitioners with a framework for intervention in the interprofessional practice setting. The framework has been designed to be used in both everyday and crisis situations, with emphasis on individual practitioner intervention. At these early stages the long term applicability of the tool has yet to be tested and the chapter considers the frameworks' potential uses, further development and broader application.

8.1 The frameworks' contribution to practice

Six concepts have been developed to form a conceptual framework for interprofessional, learning disabilities practice. The purpose of the framework being to act as a tool to assist practitioners in their personal development for practice. Fawcett (1995, p.3) cites Frank (1968, p. 45) who writes that a conceptual model or framework should offer a coherent way of thinking about events and processes. A framework offers a distinct frame of reference and is an approximation or simplification of reality, and includes only information that the author considers relevant to understanding (Reilly, 1975). Additionally a framework should afford those who are using it, room to question the approach together with a solution to practical problems.

It is intended that this model will be used as a iterative tool for practice , enabling practitioners to critically reflect on their previous and next stage interventions. It will enable the practitioner to make explicit practice thinking and action, by drawing on the framework concepts. It offers a structure for planning practice intervention, identifying areas of uncertainty, planning next stages of action, and exploring the ongoing processes and their effect. The nature of power and ambiguity within practitioner activity will be openly addressed.

8.2 How it could be used : Potential Application

The framework could be operationalised as an educational tool for practitioners in a number of ways. These include:

1. Underpinning curricula in relation to interprofessional work for qualifying education For example in pre-registration nursing and social work degree programmes in the field of learning disability, or in generic foundation programmes for health care professionals.

2. Supporting post qualifying curricula in shared learning activity in learning disability practice.

3. As a foundation for determining team work activity, focus and evaluation, in single professional teams or in interprofessional team contexts, in learning disability practice. The model may help practitioners articulate or set out what they do (Neff, 1991, p. 534).

4. As the starting point for models of interprofessional supervision and assessment.

5. As an individual practitioner focussed tool for reflection, used with supervisor support.

6. As an aid to discussion about interprofessional action with People with Learning Disability and or their families.

8.3 The Conceptual Framework and Valuing People

The conceptual framework offers a number of responses to interprofessional practice in the field of learning disability. In doing so it is ideally placed to enable practitioners take forward and or question key elements of the White Paper Valuing People (DOH, 2001)(See chapter 3, section 3.6 and 3.7). The White paper focuses on valuing difference and diversity of people with learning disability in line with the current governments' policy. Identifying social exclusion, dependence, lack of rights and choice of people with learning disability as key

problems, the government sets out its strategy for change based on collaboration between agencies and inclusion of people with learning disability.

One of the key areas identified for change is that of improving health (DOH, 2001,p.59). As explored in this thesis, (chapter three, section 3.4.6) wider health services have shown a lack of interest in this group of people. Here health improvement is used as one example of how the conceptual framework might facilitate practitioners to create change. Initially the concept 'knowledge of people with learning disability' supports practitioners to engage with people with learning disability and or their carers and advocates in relation to their perception of their current health status. This can then be underpinned by more specific theoretical knowledge if there are particular or underlying concerns for example with a chronic condition like diabetes mellitus. The impact of the context in which the individual is situated is also examined as part of the concept 'Contextual Socialisation'. For example the practitioner may question the economic and or social circumstances of the person and their family and its impact on general health. As the White Paper notes often parents with children or adult family members with learning disabilities have diminished earning potential because of care requirements (2002,p30). Equally families from ethnic minorities are at even greater risk of poverty.

From this informed position practitioners can critically evaluate the nature of power (Empowerment Concept) and how it is operating for the person and his or her family. This can also ensure also that their own role as professional is assessed. To what extent is the person empowered in terms of making decisions about his or her health ? Are structural conditions impacting on their position? Are local circumstances contributing to empowerment for example in relation to the role of primary care trusts and their investment in facilitating screening for this group of people ? Is the person being denied access to services because of a combination of learning disability and language barriers due to ethnicity?. To what extent is my position powerful in creating change here ?

As the practitioner continues to engage with these issues, the concept conflict management enables the practitioner to question the appropriateness of interventions to create change. For example is a competitive conflict style appropriate when seeking access to resources ? How would this impact on future relationships in the interprofessional team ? Is a more accommodating style of conflict management more likely to be effective in the longer term and in the spirit of collaboration ? In conjunction with the concept transforming

capability interprofessional actions can be planned . This is likely to involve the practitioner in developing new practice skills and characteristics and seeking new ways of working.

In relation to promoting health of people with learning disability a number of organisational constraints may need to be overcome, in particular when working with different agencies that also impact on health care. Strategies for building new networks may be needed with a more developed informal and formal knowledge of other agencies, for example housing or in the case of older people with learning disability, gerontology teams in the acute or mental health sector. The framework can facilitate the practitioner to assess his or her knowledge and skill in relation to these emerging new areas of practice, questioning current motivation, strategies and interprofessional relationships. The potential for leadership and their position in terms of changing responses to people with learning disability can be reviewed and actions planned.

Finally the concept interprofessional reflection- on- action offers the practitioner the opportunity to continuously reflect on their interprofessional actions so far. The success or failure of intervention so far can be evaluated. The other concepts in the framework can be revisited and new strategy planned. Areas of strength can be highlighted and further areas of new activity considered.

The framework is particularly significant when the White Paper is discussed because it focuses on building interprofessional relationships so central to it's success. Offering a model of working which may strengthen the leadership role of the RNLD and creating change for people with learning disability, the framework sits well with contemporary policy goals.

One key factor is that the framework recognises the contextual and structural issues that impact on the lives of people with learning disability as well as the practitioners's own practice (Gilbert, 1993, p.1605). Equally it offers a place for values such as those of the theory social role valorisation (Wolfensberger 1991) to be explored, (for example in the Concept Knowledge of People with Learning Disabilities). However it is not driven by this single theory that many other professionals and indeed service users and their families may be unfamiliar with.

In this sense it may represent a paradigm shift for the RNLD in that it offers a different set of 'global ideas about the individuals, groups, situations and events of interest to a discipline' (Fawcett, 1992, p. 66).This is because the framework encourages practitioners to seek formal theory and knowledge from a range of disciplines and sources. For example in

relation to promoting health, this might include accessing both the medical and social models of care. The framework encourages a different perspective on practice, with a more formal concern for values as part of the knowledge concept 'knowing the person with learning disability'. For example it may be more effective for a practitioner to reflect on the usefulness of social role valorisation as formal knowledge when seeking to address the needs of one individual at a specific point in time rather than as an unequivocal driver for every practice response.

More controversially using the framework would mean that the RNLD may have to take a more critical and contemporary position in relation to the foundations of their values and knowledge, similar to that of other professional groups. This could be significant when overcoming marginalisation and seeking greater credibility as leaders. Equally by reflecting on their current values and knowledge the RNLD practitioner may become more articulate in expressing his or her role and action to others, at a time when a consensus on definition and purpose still remains absent (Stewart and Todd, 2001).

In practice the RNLDs' distinctive relationship with people with learning disability would not change. The framework facilitates a relationship that embraces the diversity and difference of people with learning disability in the 21st century, centred on interprofessional practice to create change. What may be in transition however is the ideological foundation of the learning disability nurse, and this framework both captures (through description of practice thought and action of participants) and facilitates (through prescription, in the analysis of possible practice action ie 'what should happen' from participants) this process.

8.4 Case Scenario of Practitioner Experience

At this stage it would be inappropriate to make prescriptive statements about the specific methods of educating practitioners to use the tool in any of the above situations. However a brief example of the envisaged practitioner use of the tool is possible.

Stage One

Practitioner attends taught workshop on the framework as part of interprofessional practice module
Concepts of the framework are explored , clarified, questioned
Framework integration and coherence is critiqued

Stage Two

Practitioner works through case example to solve practice problem, using framework to determine professional action
Practitioner evaluates action, reflects on position and plans next stage of action.
Throughout the nature of power and its' use is central to the process
Practitioner uses framework in practice setting
Critically analyses use and reflects on own professional action
Questions outcome and experience and plans next intervention using framework as a practice guide, and as basis for supervision

Figure 15. *Case example of framework application*

8.5 Example of Practitioner use of framework

In the case example/ problem solving stage of the educational process, the framework will be used as a guiding tool for critical analysis of practice. For example in exploring the concept Contextual Socialisation, a practitioner may find it helpful to ask themselves a series of questions related to the context. These might include "What do I mean by political issues in this situation?", "What are the broader political issues in this practice situation? " What is the likely outcome of a practice intervention which ignores the political context in which it takes place ?" , Will it impact directly on the practice outcome? "Where does my role fit in the political context", and "Can an understanding of the political situation help in the balance of power in the practitioner and service user relationship?". Equally they may also reflect on the second part of the concept, socialisation , seeking to clarify their current position. For example "What is familiar about this practice intervention? Have I knowledge and skill to work in this type of teamwork environment? How comfortable am I with the uncertainty present for me? What are the issues related to level of comfort I need to address? The form and focus of questioning will vary from practitioner to practitioner depending on their experience.

All of the framework concepts will be explored holistically and sequentially as in the

framework model in order to guide decision making and ensure that examining the nature of power remains central to the practitioners' practice action.

8.6 The Robustness of the framework

Fitzpatrick and Whall (1996, p.17) offer a criteria for analysis and evaluation of practice theory in nursing. Here it is adapted to provides a general structure for validating steps towards practice level implementation of this framework. The criteria is separated into three distinct categories which are addressed separately below.

8.7 Criteria for the analysis and evaluation of practice theory (From Fitzpatrick and Whall, 1996 p. 17)

Basic Considerations	**Framework Capacity**
Definitional Adequacy: Can the concepts be readily operationalised?	1) Descriptions of practice theory form the concept development in chapter seven 2) The concepts have immediate application to practice in the educational setting 3) Following educational input can be immediately implemented in the interprofessional practice setting.
Empirical Adequacy Are the operationalised concepts congruent with empirical data?	1) This would form part of future testing of the model based on practitioners' responses to its fittingness.
Statement/Propositional Adequacy Do the statements assist in developing directives for care/ intervention?	1) Chapter Seven has explored the inter-relationship of all concepts in the framework and made explicit their congruence. 2) Practice Level testing for congruence will form part of future testing 3) The framework offers a starting point for interprofessional practice.

Internal Analysis and Evaluation	Framework Capacity
Are there gaps or inconsistencies in the theory that may lead to conflicts and difficulties?	1) This has been explored in the framework development in chapter 7 2) Conflict is a formal element of the framework to address practice based difficulties see chapter 7, section 7.10.1 3) The framework attempts to address the inconsistency of some concepts used in practice and clarify their meaning and application eg Knowledge of the person with learning disability see chapter 7, section 7.7.1
Assumptions of theory Are they congruent with interprofessional and learning disability practice history?	1) Framework acknowledges the potential historically situated marginalisation of the client group and impact on professionals 2) Framework makes explicit issue of power in practice and it's contested nature in interprofessional relationships and interactions
Are beliefs of framework consistent with existing ethical standards and social policy?	1) Framework concepts address the ambiguous nature of policy implementation and professional roles see discussion on socialisation chapter 7, section 7.6.1.8 2) Framework explores relationships with people with learning disabilities in an ethically sensitive way. see discussion on expert roles chapter 7, section 7.7.1.4

External Analysis and Evaluation	Framework Capacity
Is practice theory consistent with existing standards of professional practice, and of external agencies?	1) Standards of Care :There are no formal standardised protocols for interprofessional practice 2) Congruent with UKCC (And new replacing body NMC)and CCETSW (Council for Social Care) guidelines re ant-discriminatory practice 3) External Research Agencies : First stage of process is the formal examination of this thesis
Is practice theory consistent with educational standards for interprofessional learning disability practice?	1) Formalises through the generation of research evidence, elements of educational requirements of professional groups of nursing and social work. 2) Framework begins process of formalising practice level theory in a new area of practice. 3) Description of concepts in chapter 7 has highlighted the fittingness, neutral or negative relationship of framework concepts with interprofessional learning disability practice.
Is the practice theory supported by existing areas of research in interprofessional practice, learning disabilities practice and beyond?	1) The development of concepts has involved the exploration of research in a wide area of subject disciplines, related and applied practice areas

The conceptual framework developed here stands up well to Fitzpatrick and Whalls' (1996 , p .17) criteria. Two areas for future attention are:

1) External evaluation of the model in practice with practitioners to begin the next post thesis stage of formalising theory:Secondary dissemination (Rossi and Freeman, 1993)
2) External research validation to include primary dissemination (Rossi and Freeman, 1993) in the public domain

As a practitioner it is important to me that the framework developed has relevance to other practitioners. Swanson *et al* (1997, p. 267) offer a set of questions on which to evaluate the clinical (or practice) application of qualitative research. I have found them useful as a means of examining the frameworks' potential accessibility to other practitioners .

8.8 Relevance to practitioners

Swanson et al (1997, p. 267) offer sixteen areas of questioning in relation to clinical or practice applicability. These are responded to in turn below.

Questioning Practice applicability	Framework Design
1) What is the storyline (or theory) about?	Guided by Practitioner generated theory From the world of practice. Captures practitioners' responses in a formal framework for practice
2) Does the story line fit with the practitioner experience in practice or has it to be a forced fit?	Guided by Glaser and Strauss (1967) note that theory induced from data , as in this framework, and reflecting multiple realities is more likely to be applicable in practice.
3) Can the practitioner understand what the researcher is saying?	Guided by: Theory should be understandable to lay persons (ie non -researchers) working in an area (Glaser and Strauss, 1967).Concepts should be abstract and analytical for the researcher yet help practitioners make better sense of practice and support service users. For example for each of the framework concepts, the accompanying practice characteristics, defining attributes and characteristics should enable the practitioner to grasp meaning in practice setting.
4) Is the theory general enough to apply to situations practitioners meet on a daily basis ?	Guided by : Theory must be general enough to be applied in a range of practice situations.(Glaser and Strauss, 1967) Framework designed to address new, unique and ambiguous interprofessional practice situations as well as more familiar activity.
5) Does the story line account for a wide range of behaviour seen in the practitioners' setting over time ?	Guided by: Theory must be flexible enough to be reformulated in practice even on the spot to help make sense of change (Glaser and Strauss 1967). Concept Contextual Socialisation explores practice setting, policy context, service ideologies and their likely impact. Framework has reflective interprofessional reflection -in - action concept for continual and continuous practice development.

Figure 16. *Practice applicability of the conceptual framework* (Adapted from Swanson et al (1997 p. 267)

6) What are the concepts presented in the findings? Are they just named or are they supported by their characteristics? Are concepts linked to one another?	Guided by : Theory accounts for change, sufficiently general to have relevance in changing conditions of practice (Swanson et al, 1997) Framework has concepts which account for change Eg Contextual Socialisation. Transforming Capability. Concepts are supported by practice characteristics. concept antecedents and consequences. All concepts link to offer room for theory to expand and develop

Figure 16. *Practice applicability of the conceptual framework* (Adapted from Swanson et al (1997 p. 267) Con't

7) Are there conditions to show how the theory varies?	Guided by : Theory having sufficient general concepts and inter-relationships between them, so practitioners can draw on them in practice. Framework has a range of concepts which all encourage practitioners to think broadly about the practice intervention and thus apply knowledge ,question approach and have autonomy in the situation. Designed to enable flexible, reflective response not rigidity.

Figure 16. *Practice applicability of the conceptual framework* (Adapted from Swanson et al (1997 p. 267) Con't

8) Can the practitioner expand on the theory by thinking of other conditions under which the theory would be applicable?	Guided By : Controllable variables (Glaser and Strauss1967) which have maximum explanatory power ie they must make a difference by helping practitioners awareness and therefore effectivity. Framework has concept Transforming Capability which explores relationships in the interprofessional team , practitioner can examine these more closely and their impact on the change process. Enables other strategies for change to be explored.
9) Do the researchers state how a theory can be applied in practice?	Guided By: Access variables (Glaser and Strauss 1967) Enable practitioner to take account of people who have control or access to the setting. Eg Professional rules are access variables. In this study policy in relation to professional roles could be considered as professional rules Framework includes concepts of: Contextual Socialisation which examines social policy and impact eg in relation to leading on aspects of care. Empowerment, which explores nature of power in interprofessional setting. This includes impact of organisational roles, resource issues and professional status. Knowledge of People with learning Disability affirms rights of person with learning disability and seeks intervention based on negotiated roles for service users and practitioners

Figure 16. *Practice applicability of the conceptual framework* (Adapted from Swanson et al (1997 p. 267) Con't

10) Does the theory increase awareness of sociological psychological, moral, ethical or organisational aspects of practice?	Framework would be underpinned throughout by a concern with sociological, psychological, moral, ethical or organisational aspects of practice. See all concepts and defining attributes.
11) Does the theory suggest accountability for the above or just for technical aspects of practice ?	Framework driven by practitioner accountability , concept interprofessional reflection -in- action supports reflexivity in relation to sociological, psychological, moral, ethical and organisational aspects of practice. Concept Conflict Management examines practitioner response in crisis situation and levels of accountability. Concept Working with Power actively questions practitioner response to nature of power in interprofessional interaction.
12) Does the theory suggest response pre- and post institutionalisation?	Framework application is explored in chapter 8. section 8.2
13) Does the theory suggest concepts that will serve to guide the practitioner regarding aspects of use ?	Framework concepts offer practitioner a guide to use. Framework presented as a series of inter- related , sequential concepts . For example concept Working with Power cannot be understood fully in terms of likely practice outcomes , if clarity of understanding of concepts Knowledge of People with Learning disabilities and Contextual socialisation is not achieved.
14) Are issues presented from the research that can be raised among the general public?	Framework could form the basis of debate concerning desired / undesired professional and interprofessional roles with People with Learning Disability.
15) Does the research address empowerment issues for consumers, families and communities?	Framework Concepts Knowledge of the Person with Learning Disability and Working with Power consider the nature of power, professional/ Service user relationships, Professional Knowledge/ Personal Experience of Learning Disability

Figure 16. *Practice applicability of the conceptual framework* (Adapted from Swanson et al (1997 p. 267) Con't

16) Does the research address the role of the social system (such as the health care system) in addressing the social problem?	Framework affirms the need for practitioners to be informed of the context of care/ support and its' influence on alleviating, maintaining and complicating intervention in Concepts Contextual Socialisation and Working with Power. .

Figure 16. *Practice applicability of the conceptual framework* (Adapted from Swanson et al (1997 p. 267).

Responses to Swanson et al s'(1997) series of questions confirm a firm practice application for the research. The next step in development of the framework is to begin this process, which is beyond the scope of the present research. Equally further primary dissemination in the public domain through presentation and journal publication will also inform the researchers' action.

Section 8.3 offers a case scenario of one application of the tool in the educational and clinical practice setting. However a research utilisation model (From nursing, Cronenwett, 1995) could be used to assist the individual practitioner in implementing the research findings and conceptual framework from this point.

8.9 Practitioner Application

This chapter has explored the relevance or applicability of the framework as a practice tool. A systematic exploration of the framework content has shown that the research has a role to play in the real world . Further dialogue with practitioners will begin this process of dissemination as part of future studies.

Chapter Nine
Concluding this stage of the Journey

Previous chapters have charted the processes involved in answering the research question "How do professionals in the field of learning disability view interprofessional practice?". The end result being the development of a provisional conceptual framework for interprofessional practice. Chapter eight has identified some potential applications in practice for the tool, and a series of future actions have been outlined. These developments mark the end of this part of my research journey and set the scene for the next. In this concluding chapter I will reflect on the personal experience of developing the framework so far and its' contribution to the field of learning disability practice and the long term support of people with learning disability.

9.1 On Return to the Real World

9.1.1 The Research Process and the Researcher Role

One of my main concerns when setting out on this research journey was that the experience might distance me from the real world of practice. In earlier chapters I have explored the fears caused by my belief in the perfect nature of research in comparison to the somewhat prosaic status of practise. Looking back I now feel that some of these feelings were created by my struggle to stay in touch with reality, and at the same time produce a meaningful piece of research. Of course it is easy to dismiss this as the insecurity of a novice researcher or as the practitioner who when faced with change clings frantically to the safe and the familiar. In retrospect however I believe that this concern with real world issues in relation to everyday practice has been positive, and has contributed to my understanding of the value of research. The following sections summarise the research process and set out the achievements of this research study.

9.1.2 Connecting with the Real world : How do professionals in the field of learning disability view interprofessional practice?

This thesis has described in detail my research journey in response to the question "How do professionals in the field of learning disability view interprofessional practice?". The research journey has involved three inter-connected stages. A critical review of the context of interprofessional practice has been presented in chapters two to four, whilst a debate around methodology surfaced in chapter five. This was caused by my desire for order on one hand and participant focussed research on the other, and coming to a head in relation to the applicability of a semi-structured questionnaire, designed initially to confirm formal and experiential knowledge of participants and the researcher. A secondary aim of the questionnaire was to establish a group of participants for the second stage of the research which was to involve semi-structured interviews, and to identify further topic areas.

Exploring the general principles of grounded theory resolved the personal and methodological issues surrounding my engagement with the research. Continuing on the journey, the analysis of data from the questionnaires was carried out using Bogdan and Biklens' (1992, p. 166) coding categories. These offered a structured frame for the categorisation of the data which was adapted to incorporate a values / beliefs category.

Data analysis did confirm the congruity of the formal knowledge of the literature of interprofessional practice, for the participants and the researcher. However the data also highlighted some contradictory findings when practice knowledge was explored. It seemed that some individual practitioners had a more developed, understanding of the nature of interprofessional work and their professional role. However the questions asked of the data in relation to potential causes of difference among participants and based on the initial thoughts of the researcher were at this point to be inconclusive.

Therefore stage two of the research process, presented in chapter six, was designed to explore the nature of this understanding of interprofessional practice further, in a conversation with the research participants. Ten of the original group of participants agreed to pursue further their role in the interprofessional context. Themes generated from the original questionnaire were used to design the semi-structured, topic focussed interviews.

9.1.3 Stories with meaning

After the interviews, the analysis of data involved its' categorisation under a set of themes that were derived from the data. These categories and their properties, produced a description of the practice setting generated from the practitioners' experience and informal knowledge. The descriptions or stories (Payne, 1995) prompted the researcher to further explore the data within the categories asking questions of it. Through this reflexive process a series of roles, knowledge claims and engagement with power for the participants was established. For myself, these representations in the data both challenged and confirmed my previously held knowledge of the RNLD group, and finally set aside the issue of difference which I now viewed as based on my agenda and belonging to a different research study altogether. What was emerging was a picture of a confident, critical thinking, informed practitioner. Key in this stage of analysis was an RNLD who demonstrated familiarity with ambiguity of context in teamwork, an understanding of the conflicting forces of power in professional and service user relationships and interestingly, conflict management and crisis work were frequent.

Clearly there were parallels with existing literature in interprofessional practice, and health and social care, although there was limited theory in the learning disability field to draw on. Yet what the data seemed to be saying at this stage was something new in the form of a personal strategy for practice in the interprofessional context.

9.1.4 Towards a Conceptual framework

At this point the next stage of analysis which was to become stage three, had to confirm or refute my interpretation. In chapter seven, through the drawing out of practice characteristics grounded in the descriptive analysis, a set of provisional theoretical concepts for a conceptual framework were identified. Crucial to this part of the journey was congruence of meaning between practitioner generated accounts and the wider literature and research. The process used to confirm or clarify micro-level or practice theory development was concept analysis.

This critical third stage of the research journey gave the evidence in the data for the proposed concepts and their inter-relationship which are presented as a conceptual framework proto-type and in response to the question "How do professionals in the field of learning disability view interprofessional practice?". The potential range of application for the model was explored in chapter eight, whist the remainder of this final chapter demonstrates the contribution made by this study, to research and practice in the field.

9.2 Connecting with the real world: What does the study add to the understanding of the RNLD role?

Despite recent governmental support for the RNLD (DOH,2001) and the ongoing defence of the professional group that are learning disability nurses, an analysis of the literature for this research, has shown that there remains only a limited exploration of the contribution of the RNLD in the interprofessional team, or that takes forward the theoretical base underpinning the professional role. This study in capturing practitioners' views about practice takes forward understanding of the RNLD role by:

- Confirming the facilitation and collaborator role of the RNLD and endorsed in Valuing People (DOH, 2001) with research evidence.

- Identifying a clear leadership role for the RNLD in the interprofessional context.

- Highlighting the advanced interprofessional knowledge of the RNLD underpinned by applied practice examples.

- Demonstrating the ability of the RNLD to respond to change and ambiguity created by policy shift, through an exploration of their socialisation processes.

- Exploring the relationship of the RNLD and people with learning disabilities in relation to forms of knowledge held.

- Challenging the historically devalued status of the profession in the exploration of the use of power in the interprofessional context.

- Offering examples of problem solving in relation to interprofessional practice issues. These include conflict management, interprofessional relationship building, accountability , crisis management and advocacy.

- Presenting accounts of practice which illustrate reflection and personal growth.

9.3 Connecting with the Real World : How the research contributes to better practice

Through capturing the views of participants and in the generation of the conceptual framework, this research will contribute to practice in a number of ways. These include:

- Helping practitioners learn. The application of the conceptual framework in a range of settings, for example real practice, scenario based practice, reflection and supervision sessions will enable a critical engagement with crucial factors that impact on interprofessional practice.

- Problem solving. The framework can be used to assess the likelihood of problems, highlight potential problem areas, minimise problems or to seek solutions to problems in the interprofessional practice area.

- Identifying success in interprofessional team working and offering more formal means of highlighting the factors that have contributed to a successful outcome. This supports evaluation processes and also benefits practitioner learning.

- Learning from unsuccessful interventions. The framework offers a structured means of highlighting critical factors that may have contributed to unsuccessful outcomes. It offers a more structured foundation for seeking answers rather than laying blame or best guessing.

- The framework can be shared with other practitioners or professionals in order to assess progress and challenge provisional strategies in relation to outcomes for service users.

- Building relationships. The framework has the scope to be used in team building workshops or exercises, it could be used to confirm shared or different knowledge bases, experiences of practice settings, ideologies and socialisation. Similar, shared or differing expectations in relation to professional roles may be explored. This could

enhance understanding of a particular professions' responses to people with learning disability.

- Clarifying and Challenging Relationships. The framework could be adapted (through use of signs, symbols or software) for use in partnership with people with learning disabilities and or their advocates. Emphasis could be placed on exploring potential responses from the interprofessional team to needs expressed by an individual or their advocate, or in challenging unwanted or inappropriate decisions made by the interprofessional team.

9.4 Connecting with the real world : Adding something new

The development of this framework and its' potential application as an individual or shared tool for practice makes an innovative contribution to the field.

- It offers the beginnings of a new model for practice, whilst the use of a broad grounded theory approach enables further refining and developing of the concepts in the light of feedback from practitioners and as the context of practice changes.

- The research offers new practice knowledge about interprofessional work in the field of learning disability.

- It develops further the understanding of the RNLD role. in offering an account of the everyday practice experiences of this group in the interprofessional context, which remains under researched at present.

- It is accessible or user friendly. Many general nursing models are perceived as too complex for everyday practice (McKenna, 199o). This framework offers a structure for use in practice which is straight forward, with readily identifiable components. The relationship between concepts is mapped out in a two dimensional model and gives the user immediate information about the components. The model may have a wider applicability in other fields of practice with different client groups.

9.5 And Finally

This research has centred upon a group of practitioners who have largely remained out of the limelight in their everyday roles. In exploring their personal strategies for interprofessional working a vivid picture of creative and transforming practice has emerged and been consolidated in the generation of a conceptual framework. Whilst this will not bring the group fame and fortune it does offer a formalisation of their vision for practice.

What I have tried to do on this research journey is to stay with that vision. This has not always been easy and at times barriers have got in the way. However by careful attention to their origins, I have been able to explore my own beliefs, agenda and conflicts about research. In doing so ensuring that whilst it has been my research journey, it is the participants' contribution that has guided it and marks the arrival at our destination.

Appendix A1 Interprofessional Practice Questionnaire

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12].

☐

[b] Learning and working together [with other professionals]

☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975]

☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles

☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] _____

[b] _____

[c] _____

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☐ No ☐

4. How is this indicated?

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5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

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[b] Which parts of your course were interprofessional in focus. Please describe.

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6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

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Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

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2. In what way does your physical environment help or hinder interprofessional work?

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3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

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4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

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5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

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6. In your view, how do service managers demonstrate interprofessional work?

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7. In what way is interprofessional work regarded by your organisation/service?

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Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☐

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☑

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] Good interpersonal relationships.

(c) [b] lack of defensiveness about professional roles

(b) [c] Joint respect for separate autonomy as individual professionals.

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

But job-description is very old and needs up-dating unavailable now

4. How is this indicated?

Currently being re-written.

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

1% - very vague guess.

[b] Which parts of your course were interprofessional in focus. Please describe.

① Placements: Special School - 8 weeks
Child Development centre - visits.
Health Visitor / District Nurse - visits with
Social worker - 1 day.

② Teaching whilst in school ie. Physio, Dietitian, Psychiatrist, Psychologist.

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

"Helps" - client is getting appropriate and expert help from professional who focusses on particular needs which might be missed without their involvement. If professionals liaise closely their input can be tailored to clients total needs. Professionals need to be aware of the rationale for each other's input so that client gets a coherent and organised service; with each others professional "messages" reinforced (if agreed.) (PTO)

Avoids client being bombarded by visits and appointments if contact is coordinated.

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

Everyday practice: because liaison with other professionals is always necessary to facilitate the aims of Community Nursing involvement eg. gathering information; assessment.

2. In what way does your physical environment help or hinder interprofessional work?

Currently all community nurses are in one office, and other professionals are elsewhere - this obviously hinder the development of interpersonal relationships.

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

No. I think the personality and values + beliefs of individuals affect interprofessional working. Big egos and lack of humility are usually the biggest hinderance.

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

See enclosed Service Specification and operational Policy.

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

By talking about the aims and implementation of plans of work, and how this can be aided by liaison with colleagues.

6. In your view, how do service managers demonstrate interprofessional work?

Within health – I feel that this has become a low priority within health teams. I don't think they do demonstrate interprofessional work; either at a senior level (ie. we aren't shown how it is done) nor is it facilitated at "grass-roots".

7. In what way is interprofessional work regarded by your organisation/service?

It appears to be assumed that we will do it on an individual client basis. But as stated they appears to be a move away from multidisciplinary team attempting to work as a team eg. tackling issues jointly. No team meetings with other professionals in health exist. Only one multi-agency meeting exists (sexual health and learning disability) and this was initiated by PCTs

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☑

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] Good communication

[b] & Effective Teamwork

[c] A good understanding of the needs of the client group.

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

4. How is this indicated?

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5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

35%

[b] Which parts of your course were interprofessional in focus. Please describe.

Often used in study days

Emphasised often in my assessment document.

If the opportunity arose whilst on my practical placements, then I could take part in interprofessional work

.....

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

If it is done effectively then ~~[illegible]~~ I think interprofessional work could be beneficial for clients in meeting their needs

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

I do not feel that multidisciplinary work is part of everyday practise. I feel that it only arises when there is a problem with a particular client.

2. In what way does your physical environment help or hinder interprofessional work?

~~If the question refers to my working environment then it can help to have a neutral environment so there isn't so much distraction.~~

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

I think it depends more on the relationships within the team, and each persons personal feelings for each other.

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

None that I can think of

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

I haven't yet had a Formal Supervision session

6. In your view, how do service managers demonstrate interprofessional work?

Service Managers tend to have more contact with people outside the unit or community home, So in terms of the amount of people they meet just by seeing them, they demonstrate interprofessional work. This may also include people outside of the Service.

7. In what way is interprofessional work regarded by your organisation/service?

~~Have not actually seen~~ Having not seen a statement from the service about interprofessional work I couldn't say but I would imagine that they are fully committed to it and find it necessary for the service.

8. Are there elements of inter-professional work that you dislike?

Sometimes relationships within it can be difficult, but I find it useful and important in order to find the best resources to suit clients needs.

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☑

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] Communication

[b] Defined roles

[c] _____

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

4. How is this indicated?

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

50

[b] Which parts of your course were interprofessional in focus. Please describe.

Community Studies Primary Care team, Ambulance Funeral directors, occupational health

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

When it works good However often the 'ball' is passed between different professionals and things are not done

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

Yes As nursing is a holistic process care plans can involve other professionals

2. In what way does your physical environment help or hinder interprofessional work?

Hinders as our nursing team is isolated from any other professionals

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

Don't know - possibly more knowledge of what may be available

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

Only in that the words 'holistic', 'needs led' and 'individual'

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

Not included

6. In your view, how do service managers demonstrate interprofessional work?

liaisons

7. In what way is interprofessional work regarded by your organisation/service?

Good

8. Are there elements of inter-professional work that you dislike?

People not willing to take on board that services change over time to reflect the current needs

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☑

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] GOOD COMMUNICATION

[b] COMMON AIM - CLEARLY DEFINED

[c] KNOWING ROLES & WORK BEING UNDERTAKEN BY OTHERS SO KNOW OVERLAPPING TASKS

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☐ No ☑

DPS

4. How is this indicated?

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

20%

[b] Which parts of your course were interprofessional in focus. Please describe.

MENTAL HEALTH PATHWAY

CHILD CARE "

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

DEPENDS ON SITUATION + CLIENTS NEEDS MUST VARY ACCORDING TO CLIENTS NEEDS - THIS MUST BE PRIORITY AND LEAD TO METHOD OF WORKING

Section Two

Dp 5 - 18

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

WE LIASE WITH OTHER PROFESSION REGULARLY, BUT DAY TO DAY SUPPORT WORK IS CARRIED OUT BY OURSELVES - MAINLY BECAUSE OF GEOGRAPHICAL REASONS

2. In what way does your physical environment help or hinder interprofessional work?

BASED IN DORSET - WORK WITH S.W OVER THE COUNTRY SO GEOGRAPHICAL SITUATION CAN HINDER WORK

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

NOT A PROBLEM - CAN BE HELPFULL E.G COLLEAGUE WITH PREVIOUS MEDICAL KNOWLED CAN BE

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

TALKS ABOUT WORKING WITH OTHER AGENCIES

Dp 5 - 18

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

INCLUDED WHERE APPROPRIATE.

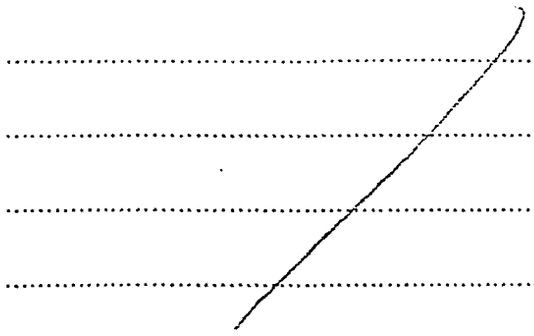
6. In your view, how do service managers demonstrate interprofessional work?

MEETING OTHER SERVICE MANAGERS - MAINTAINING GOOD COMMUNICATE

7. In what way is interprofessional work regarded by your organisation/service?

IMPORTANT AS WE RELY ON GOOD WORKING RELATIONSHIPS TO HELP PLACE + MAINTAIN ADOPTIVE PLACEMENTS

8. Are there elements of inter-professional work that you dislike?



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Appendix A2 Participant Responses

DS 1

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☑

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] good level of communication

[b] common objectives

[c] mutual respect & understanding.

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

4. How is this indicated?

By the description of the need to liase closely with the CMHT & voluntary agencies.

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

30%.

[b] Which parts of your course were interprofessional in focus. Please describe.

This was something which I thought was lacking considerably in the course & therefore can not think of any parts.

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

Interprofessional work can significantly help the client as they are able to receive a service from professionals appropriate for their needs.

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

I do think it is a part of everyday practice although unfortunately not enough is taking place for the benefit of the clients.

2. In what way does your physical environment help or hinder interprofessional work?

It helps by the the fact that the CMHT is situated in the next building so communication/referrals are a lot smoother/better.

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

It does affect interprofessional work as a hierarchy tends to form with some professionals assuming superiority over which can cause resentment & thus leading to a breakdown.

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

Yes although I'm unable to think of any examples.

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

It is not included & is something which I feel is very poor.

6. In your view, how do service managers demonstrate interprofessional work?

By giving us regular feedback about mtg. which they have attended with other agencies.

7. In what way is interprofessional work regarded by your organisation/service?

As an important aspect of work that staff are regularly involved in although the support & guidance is not offered to staff.

8. Are there elements of inter-professional work that you dislike?

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The hierachy system involved & the constant need to keep asserting your position/knowledge/expertis

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.....

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☑

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] Good communication with other professionals

[b] Valuing each others role, professionals

[c] Have clear roles but also use different skills.

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

4. How is this indicated?

I am a social worker within a community mental health team which mainly consists of medical professionals.

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

30% ish

[b] Which parts of your course were interprofessional in focus. Please describe.

With placements throughout the course centred on element of interprofessional work. The second years academic work also focused on interprofessional working as a social worker in different fields (eg children & families and mental health).

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

In my current position, interprofessional working is necessary and helpful in client's terms of meeting their social and medical needs.

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

This does depend on which field of social work is being described. In all areas of social work it is always to liaise with other professionals. Within mental health it is most certainly part of everyday practice

2. In what way does your physical environment help or hinder interprofessional work?

I am currently based at an area office along with other social work teams although I attend weekly CMHT team meetings. At present this is not a hinderance

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

Yes, within CMHTs, we are working from different perspectives eg social model and medical model

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

Not that I am aware of.

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

It is necessary when discussing cases to include medical opinions, such when consultation is required to write reports for tribunals or work relevant to the Mental Health Act 1983

6. In your view, how do service managers demonstrate interprofessional work?

By liaison and negotiation with health trusts when devising interprofessional policies and restructuring CMHTs.

7. In what way is interprofessional work regarded by your organisation/service?

As absolutely essential, although different models of working are acknowledged which cause difficulties at times.

8. Are there elements of inter-professional work that you dislike?

When working from different models, there are times when mental health medical treatment/practice is difficult to understand and disengage for clients. Also, social workers are not always fully utilised or valued by health professionals.

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☐

[b] Learning and working together [with other professionals] [Leatherhard 1990]. ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☑

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] Communication.

[b] Flexibility

[c] Awareness of others' environments

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

4. How is this indicated?

As a member of a community mental health team I am required to fulfill the role of team member.

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

Very small

[b] Which parts of your course were interprofessional in focus. Please describe.

In contrast to the spirit of the joint course I found that each part remained independent. The focus of each part was to meet the requirements of that part. Throughout, I was able to make comparisons however I enjoyed the opportunity to take a more widely based view on the management placement of RMN only.

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

One of the major hindrances to users meeting their goals remains to be conflict between agencies, particularly funding responsibilities eg S.117 after 28 days aftercare

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

As to whether interprofessional work is part of everyday practice depends very much on the individual worker and the opportunities they are afforded. Those who communicate prove more effective

2. In what way does your physical environment help or hinder interprofessional work?

I am currently completing AST training at the Dept of Psychiatry, Sirken RSH. Having Drs, CPNs, OTs in the same building is useful. Usually I have to visit the local hospital on my normal workbase to attend CMHT meetings

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

I find psychiatrists tend to adopt a band leader approach however the attitude of the professional is more significant than their profession

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

NO

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

Supervision tends more to highlight any areas of confrontation or conflict. Concentration on funding responsibilities acts as an obstacle to further development of effective multi-disciplinary work.

6. In your view, how do service managers demonstrate interprofessional work?

Adversarially.

7. In what way is interprofessional work regarded by your organisation/service?

Lip service is paid to interprofessional work, however, at an agency level it would appear that multi-disciplinary working means; these professionals dealing directly with clients/users working together in the most effective way despite funding conflicts at different levels creating obstacles to cohesive approaches.

8. Are there elements of inter-professional work that you dislike?

It can be very hard work and often it would be more simple to concentrate on the defined task at hand. However, inter-professional work is essential to develop consistent and coherent services, anything less is selling the client short.

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979. 12]. ☐

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☑

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] SPECIALIST KNOWLEDGE

[b] SHARED OBJECTIVES

[c] CLEAR DELINEATION OF INDIVIDUAL ROLES

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

4. How is this indicated?

IN TERMS OF LIAISING WITH OTHER PROFESSIONALS AND EXTERNAL AGENCIES.

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

10%.

[b] Which parts of your course were interprofessional in focus. Please describe.

EACH PLACEMENT DEMANDED WORK IN EITHER A SOCIAL WORK, VOLUNTARY OR HEALTH ENVIRONMENT THUS PROVIDING A WORKING KNOWLEDGE OF INTER-PROFESSIONAL ROLES. HOWEVER, FEW AREAS WITHIN THE COURSE FOCUSSED UPON ATTEMPTS/METHODS TO BRIDGE THE GAP BETWEEN THESE ROLES.

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

BECAUSE SEPARATE AGENCIES HAVE WIDELY VARYING OBJECTIVES AND LONG TERM STRATEGIES THIS LEADS TO INTER-AGENCY CONFLICT RESULTING IN A DELAY (AT LEAST) OF ANY SATISFACTORY PROVISION TO THE CLIENT/SERVICE USER. INDIVIDUAL BUDGETARY CONSTRAINTS APPEAR TO BE A MAJOR CAUSE OF THIS.

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

SOMETHING DIFFERENT. IT IS A MEANS TO OFFLOAD INDIVIDUAL RESPONSIBILITIES ONTO OTHER AGENCIES IN ORDER TO PROVIDE AN EFFECTIVE SINGLE AGENCY SERVICE.

2. In what way does your physical environment help or hinder interprofessional work?

LACK OF INFORMATION TECHNOLOGY, AND COLLECTIVE INTER-AGENCY DATABASES.

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

YES. IT PRODUCES A CONFLICT + CONFUSION OF ROLES.

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

YES.

DQ 16

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

With Negativity And Hostility From Supervisors Regarding Other Agencies. It Is Not Generally Encouraged Unless Totally Necessary For The Client.

6. In your view, how do service managers demonstrate interprofessional work?

Very Poorly, And With Great Reluctance.

7. In what way is interprofessional work regarded by your organisation/service?

As A Necessary Prerequisite For Practice But An Annoying One At That.

8. Are there elements of inter-professional work that you dislike?

No, it should be encouraged as it provides an escape from the stifling culture of professional 'elitism.'

Interprofessional Practice Questionnaire

Section One

Individual Views

1. Which of the following definitions of interprofessional or multi-disciplinary work do you prefer. Please tick one box only.

[a] A group of individuals with different training backgrounds [e.g. nursing - social work - medicine - occupational therapy - health visiting] who share common objectives but who make a different but complementary contribution. [Marshall et al 1979, 12]. ☑

[b] Learning and working together [with other professionals] ☐

[c] Team members have shared aims, with distinct roles for team members, working within an organisational structure to facilitate joint working and communication. [Adapted from Kane. 1975] ☐

[d] A group of professionals who work towards problem solving for clients using intervention based on individual skills rather than professional roles ☐

2. In your view, what are the three key elements of interprofessional or multi-disciplinary work? Please list below in order of importance.

[a] Comman Client Centered goals

[b] Communication

[c] Co-operation

3. In your job description is multi-professional work identified as a key part of your role? Please tick the box which applies.

Yes ☑ No ☐

4. How is this indicated?

Job description

5. How much time was given to interprofessional work in your pre-qualifying or pre-registration training?/education

[a] Please give an approximate percentage

30%

[b] Which parts of your course were interprofessional in focus. Please describe.

Mainly the Nursing focus.

6. In your view, does interprofessional work help or hinder the client in meeting his/her needs and why?

If its client centered with key elements Q2 it helps. If these are not present it hinders

Section Two

PRACTICE

1. In your opinion, is interprofessional work a part of everyday practice or something different? Please give reasons for your answer.

I can only answer from personal experience, which is part of my everyday practice. I have to pursue interprofessional practice to be able to function on clients' behalf.

2. In what way does your physical environment help or hinder interprofessional work?

I am very autonomous, have developed relationship with schools where I create my own working environment, which allows for good co-operation.

3. Do the professional backgrounds of your team members/colleagues affect interprofessional work, please give reasons.

Combined with their philosophy/ethics yes it does. If other professionals value client and we all have common goals it a good base for resolution.

4. Do the teams organisational goals or mission statement include statements about interprofessional work? Please provide examples where possible.

Yes in Job description.

5. How is interprofessional work included in your regular formal supervision and/or reflective practice sessions?

In supervision I am often guided/reminded to utilise others' professional skills.

6. In your view, how do service managers demonstrate interprofessional work?

In my experience, in our service, it is excellent with regular meetings at Service manager level to develop better ways of working in partnership and break down professional barriers.

7. In what way is interprofessional work regarded by your organisation/service?

As a necessity!

8. Are there elements of inter-professional work that you dislike?

Yes. When financial restriction (budget) prevent inter professional work from resolution of client needs.

Appendix A3

Practitioner Profiles

Rn1

Working in a small residential setting for people with profound learning disability in a semi-rural area. At the time the service also offered a respite service for adults with profound disability living at home. This form of respite seen as a break for other family members. RN

Rn2

Working in a small home for adults with profound learning disability. The service is situated in a suburban setting. The house is viewed as the permanent home of the current people residing there. RN

Rn3

Working in a house for people with severe challenging behaviour. There are no respite beds and the house is described as the permanent home of the individuals residing there. Emphasis on daily living and community integration. Crisis is likely to be managed without transfer of clients to other services.RN/DQ

Rn4

Working in a treatment service for people with severe challenging behaviour. Clients are likely to be admitted in emergency or crisis situations from other services and from home. Admission is likely to be for up to six months with an intensive programme of intervention.
RN/DQ

Rn5

Working as a member of an outreach service attached to the Community Learning Disability Team. Support to a range of families is offered where challenging behaviour or profound learning disability is an issue. This support may be viewed as crisis intervention by the family and other professionals.RN

Rn6

Working in a service for people with challenging behaviour. The service is community based with both a community and residential model of care in operation. The service is seen as a temporary home for clients, whilst problems are solved with individuals .However there are some clients who have been resident for considerable periods of time.RN/DQ

Rn7

Working in a service for people with profound learning disability in a community setting. The service is presented as a permanent home for people living there, some of whom may have terminal or life threatening conditions.RN

Rn8

Working in a service that offers residential care for young adults with severe learning disability. Individuals residing in the service are viewed as permanent members of the house. Emphasis is on community integration and support during life transitions.
RN/DQ

Rn9

Working in a small residential home for people with profound learning disability. The health needs of the individuals mean that they require nursing intervention to meet their basic needs. Often these health care needs overide all other activity in the house. There is a constant pressure for beds here from a range of services and agencies.
RN

Rn10

Working in a children and families team in social services with responsibility for disability and learning disability. Team in a area with a significant influx of military personnel.
DipSW

Appendix Tables

	Participants																	
Question No.	DS1	DS3	DS9	DS6	DS16	DS18	RNLD5	RNLD6	RNLD10	RNLD3	RNLD4	RNLD7	DQ10	DQ6	DQ8	DQ3	DQ16	DQ2
Q1 IV	a	A	c	a	A	a	a	a	a	c	a	d	c	a	d	d	d	d
Q2	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def
Q2	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def
Q2	Def	Def	Def	Def	Def	Def	-	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def	Def
Q3	yset	yset	yset	yset	yset	nset	yset	yset	nset	yset	yset	nset	yset	yset	yset	yset	yset	Yset
Q4	Def	Def	Def	Def	Def	-	-	-	-	Def	Def	Defn	Def	Def	Def	Defn	Def	Defn
Q5a	30%	30%	40%	25%	40%	20%	5%	35%	5%	1%	1%	5-10%	20%	3O%	Very Sma ll	50%	10%	20%
Q5b	Feln	Def	Def	Def	Defn	Def	Def	Defa	Def	Def	Def	Defn	-	Def	Fela	Feln	Feln	Felan
Q6	Def	Def	Def	Defn	Defn	Def	Defn	Defan	Defn	Defan	Defa	Defn	Defa	Defan	Defn	Feln	Defn	Def
Q1P	Defn	Def	Def	Defa	-	Def	Defa	Defa	Defn	Def	Def	Defn	Def	Perk	PerK	Perk Feln	Defn	Perk
Q2P	Fela	Perk	Perk	Perk	-	Def	Def	Perk	Perk	Perk Feln	Perk	Perk	Def	Perk Fela	Per Fela	Feln	Defn	Perk
Q3P	Perk	Perk	Perk Feln	Perk	-	Perk	Def	Perk	Perk	Perk Feln	Perk	Perk Feln	Def	Perk Fela	Perk	Defn	Defn	Perk
Q4P	Def	Def	Perk	Def	-	Def	Perk	Def	-	Perk	Def	Def Feln	Perk	Def	Def	Def	Def	Def
Q5P	Def Feln	Perk	Perk	Def	-	Def	Def	Def	Perk Fela	Perk	Def	Perk	Def	Perk	Perk Feln	Def	Feln	Perk
Q6P	Def	Def	Perk	Def	-	Def	Def	Fel	Perk	Perk Feln	na	Perk	Perk	Fela Perk	Feln	Feln	Feln	Perk
Q7P	Perk Feln	Perk	Def	Def	-	Perk	Def	Perk	Perk	Perk Feln	Fela	Perk	Fela	Perk	Feln Perk	Feln	Perk Feln	Fela
Q8P	Perk	Perk	Perk	Def	-	-	Perk	Perk	Perk	Perk	Perk	Perk	Perk	Perk	Perk	Feln	Fela Feln	Perk

Table A1. *Participant Question Response Codes (Questionnaire)*

Area of Analysis	Emerging Theme
Knowledge Based responses(Section5.8.1)	
Interprofessional Knowledge	Interprofessional Knowledge(Theme1)
	Role of the RNLD(Theme2) Social Care practice(theme4)
Opportunity for interprofessional work	Role of the RNLD (Theme2) Health Care Roles (Theme3) Social Care Practice (theme 4)
Roles of other professionals	Health care Roles(Theme3) Social Work practice (Theme 4) Interprofessional Knowledge (Theme 1) Influence of DQ (Theme5)
Values	Influence of DQ (theme5) Educational experience (Theme6)
Professional equilibrium/ power	Interprofessional Knowledge (Theme1) Influence of DQ response (theme5) Health care roles(theme3) Social Care practice(theme4)
Length of response on questionnaire	Influence of DQ(Theme5)

Table A2. *Table indicating emerging themes from section 5.9.2 knowledge type responses*

Area of Analysis	Emerging Theme
Language Used	Knowledge of Interprofessional Practice (Theme1) Educational Experience (Theme6)
Questioning / barriers to Interprofessional Practice	Knowledge of Interprofessional Practice (Theme 1) Health Care Roles (Theme3) Social Care Practice (Theme4) Role of the RNLD (Theme2) Influence of DQ (Theme5)
Lack of resources	Knowledge of Interprofessional Practice(Theme1)
Role of managers	Knowledge of interprofessional Practice (Theme1) Health care Roles (Theme3) Social Care practice (Theme4) Role of the RNLD(Theme2)

Table A3. *Table indicating emerging themes from section 5.9.3 Language and Professional Practice*

Area of Analysis	Emerging Themes
Professional Language	Role of the RNLD (Theme 2) Educational Experience (Theme 6) Social Care Practice (Theme4) Influence of DQ (Theme5)

Table A4. *Table indicating emerging themes from analysis of 5.9.4 Justifying response*

Area of Analysis	Emerging themes
Professional Culture of Nursing	Role of the RNLD(Theme2) Educational Experience (Theme6) Health Care Roles (Theme3)
Professional Culture of Social Work	Social Care practice (Theme4) Educational Experience (Theme6)
Clinical Role and Judgement	Role of the RNLD (Theme 2) Interprofessional Knowledge(Theme1) Social Care Practice (Theme4) Health Care Roles (Theme 3) Educational Experiences (Theme 6)
Professionalism	Role of the RNLD (Theme 2) Social Care Practice (Theme4) Educational Experiences (Theme 6)

Table A5. *Table indicating emerging themes from analysis of 5.9.5 Professional Culture*

Area of Analysis	Emerging Themes
Value based language of DQ	Influence of DQ (Theme5) Educational Experience (Theme6)
Group Identity of DQ	Influence of DQ (Theme5) Educational Experience (Theme 6)
Professional View of self and others	Educational Experience (Theme 6) Role of the RNLD (Theme2) Social Care Practice (Theme 4) Health Care Roles (Theme 3) Interprofessional Knowledge (Theme 1) Influence of DQ (Theme 5)
Boundary issues	Role of the RNLD (Theme 2) Interprofessional Knowledge (Theme 1) Social Care Practice (Theme 4) Health Care Roles (Theme 3) Influence of DQ(Theme 5)

Table A6. *Table indicating emerging themes from analysis of 5.9.6 Professional Accounting*

Area of Analysis	Emerging Themes
Lack of power	Interprofessional knowledge (Theme1) Role of the RNLD (Theme2) Health Care Roles (Theme 3)
Empowerment	Role of the RNLD (Theme 2) Influence of DQ (Theme 5) Educational experience (Theme 6) Social Care Practice (Theme4)

Table A7. *Table indicating emerging themes from analysis of 5.9.7 Professional Equilibrium*

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